

In the Matter Of:  
The Long-Term Care Homes Public Inquiry

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DAY 20 / VOL 20  
July 18, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

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--- 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 Stabblers, CSR, RPR

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3     & Lindsay Merrifield, Esq.,  
4     & Rebecca Jones, Esq.,  
5     & Laura Robinson, Esq.,  
6     & Christina Shiel-Singh, Esq.  
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8     Jared B. Schwartz, Esq.,            AdvantAge Ontario  
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10    Jane Meadus, Esq.,                 Ontario  
11    & Susan E. Frazer, Esq.,            Association of  
12   Residents'  
13   Councils  
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15    David M. Golden, Esq.,             Caressant Care  
16   Nursing and  
17   Retirement Homes  
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19   Caressant  
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22    Megan Schwartzentruher,            College of Nurses  
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25    Paul H. Scott, Esq.,                Jon Matheson, Pat  
26   Houde, Beverly  
27   Bertram  
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29    Rita Bambers, Esq.,                 Her Majesty the  
30    & Meagan Williams, Esq.,           Queen in Right of  
31   Ontario  
32

1     A P P E A R A N C E S (CONT'D)  
2     Alex Van Kralingen, Esq.,     Arpad Jr. Horvath,  
3                                     Laura Jackson, Don  
4                                     Martin, Andrea  
5                                     Silcox, Adam  
6                                     Silcox-Vanwyk,  
7                                     Shannon Lee  
8                                     Emmerton, Jeffrey  
9                                     Millard, Judy  
10                                    Millard, Sandra  
11                                    Lee Millard,  
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14                                    Susie Horvath.  
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16     Nicole Butt, Esq.,             Ontario Nurses  
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19     Chris Hubbard, Esq.,         Dr. George  
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09:34:21 1 --- Upon commencing at 9:34 a.m.  
09:34:26 2 THE COMMISSIONER: Morning,  
09:34:26 3 Ms. Robinson.  
09:34:27 4 MS. ROBINSON: Morning,  
09:34:29 5 Commissioner. We intend to  
09:34:31 6 proceed this morning with further  
09:34:33 7 examination of Dr. Mann by  
09:34:35 8 Ms. Bambers on behalf of the  
09:34:37 9 Province.  
09:34:38 10 THE COMMISSIONER: All right.  
09:34:38 11 Thank you.  
09:34:41 12 Good morning Dr. Mann. Welcome.  
09:34:44 13 THE WITNESS: Morning.  
09:34:44 14 DR. RICHARD MANN: PREVIOUSLY AFFIRMED  
09:34:47 15 EXAMINATION IN-CHIEF BY MS. BAMBERS:  
09:34:58 16 Q. Morning, Dr. Mann.  
09:34:59 17 A. Morning.  
09:35:03 18 Q. You told us yesterday that  
09:35:06 19 part of your job as a Regional Senior  
09:35:07 20 Coroner was to review CIS statements, the  
09:35:14 21 Form 3s, the coroner investigation  
09:35:16 22 statements to -- in addition to spelling you  
09:35:20 23 reviewed them to make sure they made sense?  
09:35:22 24 A. Yes.  
09:35:24 25 Q. And since the offences came  
09:35:25 26 to light you've had an opportunity to review  
09:35:30 27 the original Form 3 for James Silcox that  
09:35:38 28 Dr. George completed?  
09:35:40 29 A. Yes.  
09:35:45 30 Q. And I understand in that case  
09:35:46 31 the cause of death was determined to be  
09:35:49 32 complications from his hip fracture?

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A. That is correct.

Q. And having reviewed that statement did that raise any concerns for you when you were reviewing it?

A. At the time? That the death occurred or after the revelations about Ms. Wettlaufer?

Q. Well, I understand that you only did review it after you knew of the offences?

A. Correct.

Q. And my question is, had you reviewed that at the time would that have caused any concern for you? Did you see any deficiencies in it for the kinds of things that you were reviewing as a Regional Senior Coroner?

A. If I had reviewed is it at the time of the first -- I'm a bit confused, sorry. I'm a bit confused about the question.

Q. So had you reviewed the statement in your normal course of approving and signing off on CIS statements would there have been any concerns in that statement for you?

A. At the time that the death occurred?

Q. Right.

A. No.

Q. Thank you, those are all my questions.



09:37:04 1 THE COMMISSIONER: Thank you.

09:37:11 2 MS. JONES: Thank you. Next we'll

09:37:12 3 have Mr. Van Kralingen on behalf

09:37:14 4 of one of the family groups.

09:37:16 5 THE COMMISSIONER: Thank you.

09:37:17 6 CROSS-EXAMINATION BY MR. VAN KRALINGEN:

09:37:29 7 Q. Dr. Mann, because of

09:37:33 8 yesterday's questioning I'm not going to be

09:37:35 9 asking you about every document in that

09:37:37 10 compendium that I've provided you, just to

09:37:40 11 give you some comfort.

09:37:41 12 A. Thank you.

09:37:42 13 Q. My name is Alex Van

09:37:43 14 Kralingen, as you know I'm one of the

09:37:45 15 lawyers representing one of the victims

09:37:47 16 groups?

09:37:48 17 A. Yes.

09:37:48 18 Q. I'm wondering if you look at

09:37:48 19 the Case Selection Data Form, which is at

09:37:50 20 tab 4 of the document you have?

09:37:52 21 And, Commissioner, I've given you

09:37:56 22 the wrong document number but a comparable

09:37:58 23 document for the purposes of the public is at

09:38:00 24 document 71436.

09:38:05 25 THE COMMISSIONER: So the document

09:38:11 26 at tab 4 --

09:38:12 27 MR. VAN KRALINGEN: I've chosen a

09:38:13 28 Case Selection Data Form that's

09:38:17 29 actually not in evidence but here

09:38:19 30 this one that's on the screen,

09:38:20 31 which is 71436, is in evidence.

09:38:28 32 THE COMMISSIONER: Thank you.

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BY MR. VAN KRALINGEN:

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?

A. That's correct.

Q. How often do you do that review? How contemporaneous is that review?

A. Within a couple of days of receiving it.

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?

A. That's fair to say.

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?

A. Yes, I have.

Q. How often has that happened?

A. It hasn't happened very often.

Q. Can you explain the last, for example, scenario where that occurred?

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

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

09:42:42 1 A. Mostly on -- because of  
09:42:47 2 workload and lack of time to be able to do  
09:42:49 3 that.

09:42:50 4 Q. So resource issue, right?

09:42:51 5 A. Resource issue.

09:42:54 6 Q. We've discussed with  
09:42:55 7 Dr. Huyer the fees associated with a death  
09:42:58 8 investigation. And for death investigations  
09:43:01 9 my understanding is that local coroners can  
09:43:04 10 request additional compensation over and  
09:43:06 11 above the standard \$450 charge in  
09:43:10 12 exceptional circumstances, is that your  
09:43:12 13 understanding?

09:43:13 14 A. That is correct.

09:43:14 15 Q. And I assume that those  
09:43:14 16 exceptions are related to whether death  
09:43:18 17 investigations are either longer or more  
09:43:19 18 detailed than is usually expected, is it  
09:43:22 19 fair to say?

09:43:23 20 A. That's fair to say.

09:43:24 21 Q. Does the same principle apply  
09:43:27 22 to the payment of associated with completing  
09:43:29 23 the Case Selection Data Form? Is it  
09:43:31 24 possible to ask for an additional payment if  
09:43:34 25 completing that form or the process to  
09:43:36 26 complete that form is a longer or more  
09:43:39 27 detailed process?

09:43:40 28 A. My understanding is it is  
09:43:42 29 not.

09:43:44 30 Q. Can you go to paragraph 9 of  
09:43:46 31 your affidavit please? At paragraph 9 you  
09:43:49 32 reference --

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A. Sorry. Thank you.

Q. We're going to look at paragraph sub (d), actually over to the next page.

You indicate that you have conducted educational sessions relating to your role as a Regional Senior Coroner and the coroners office, is that correct?

A. That's correct.

Q. My understanding though is that you have not conducted such an educational session at a long-term care home, is that correct?

A. That's correct.

Q. My first question is, who are you providing the educational sessions to typically?

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.

Q. And without going into too much detail can you give me sort of an overview of the content of those educational sessions?

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 1 not hitting it all the time.

09:47:03 2 Q. Dr. Huyer had a similar issue  
09:47:05 3 yesterday so you're not unique?

09:47:07 4 A. I noticed that.

09:47:11 5 Q. So you'll see at paragraph  
09:47:12 6 6 -- not page 6 paragraph 6, sorry. It will  
09:47:22 7 be on page 2, thank you.

09:47:24 8 There's a listing after the  
09:47:26 9 narrative at paragraph 6, there's actually a  
09:47:29 10 chart there for various years and total  
09:47:31 11 deaths investigated, and that's relating to  
09:47:33 12 the total deaths investigated in the London  
09:47:36 13 office?

09:47:36 14 A. That is the total number of  
09:47:39 15 deaths investigated by the London office as  
09:47:41 16 provided by the Office of the Chief Coroner,  
09:47:44 17 yes.

09:47:44 18 Q. Fair enough. If you could go  
09:47:45 19 to paragraph 21 of the affidavit now, where  
09:47:48 20 there's a listing of the Case Selection Data  
09:47:49 21 Forms received?

09:47:50 22 I've done the math and compared the  
09:48:09 23 numbers between paragraph 6 and paragraph 21,  
09:48:11 24 and it appears that less than one-third of  
09:48:15 25 the death investigations that are conducted  
09:48:18 26 in the London region actually have a Case  
09:48:21 27 Selection Data Form submitted. Does that  
09:48:24 28 ratio seem to make sense to you?

09:48:26 29 A. I'm not sure that you're --  
09:48:28 30 that that's a correct way of looking at  
09:48:30 31 things.

09:48:31 32 Q. Okay.



09:48:31 1 A. The number -- so the first --  
09:48:35 2 the first graph or column thing that you  
09:48:42 3 provided.

09:48:42 4 Q. Yes.

09:48:43 5 A. Is the number of  
09:48:44 6 investigations, period.

09:48:46 7 Q. Right.

09:48:47 8 A. Does not include case  
09:48:48 9 selections. Case selections are separate  
09:48:51 10 because they are not investigations.

09:48:53 11 Q. Well, a case selection form  
09:48:54 12 could lead to an investigation?

09:48:56 13 A. It could lead to an  
09:48:56 14 investigation, correct. So this represents  
09:48:59 15 the case selection forms, does not -- it  
09:49:04 16 does not -- it does not subtract from or --  
09:49:08 17 it is different from the cases that are  
09:49:12 18 actually investigated.

09:49:14 19 Q. You're sort of dovetailing  
09:49:15 20 into my point here. Let's go through the  
09:49:17 21 process.

09:49:18 22 A. Okay.

09:49:18 23 Q. A best practice for a local  
09:49:20 24 coroner in London would be to use the case  
09:49:24 25 selection form in their determination as to  
09:49:26 26 whether a death investigation should occur  
09:49:28 27 at all, is it fair to say?

09:49:29 28 A. That's fair to say.

09:49:30 29 Q. So your hope would be in the  
09:49:31 30 majority of the more than 2,000 cases that  
09:49:36 31 are investigated each year that there would  
09:49:36 32 be a case selection data form associated

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

09:51:03 1 identified a concern about possible patient  
09:51:05 2 abuse, or the quality of care provided to a  
09:51:08 3 registered -- by a Registered Nurse or other  
09:51:11 4 health practitioner, is there any barrier to  
09:51:17 5 the coroners office contacting either the  
09:51:19 6 Ministry of Health or professional  
09:51:21 7 regulatory body such as the College of  
09:51:23 8 Nurses to report what they believe?

09:51:25 9 A. No.

09:51:26 10 Q. Thank you kindly for your  
09:51:27 11 time, those are my questions.

09:51:28 12 A. Thank you, sir.

09:51:38 13 MS. JONES: And Mr. Scott on  
09:51:39 14 behalf of another of the family  
09:51:41 15 groups.

09:51:41 16 THE COMMISSIONER: Thank you.

09:51:51 17 MR. SCOTT: Morning, Madam  
09:51:52 18 Commissioner.

09:51:53 19 THE COMMISSIONER: Morning,  
09:51:53 20 Mr. Scott.

09:51:54 21 CROSS-EXAMINATION BY MR. SCOTT:

09:52:00 22 Q. Morning, Dr. Mann.

09:52:00 23 A. Morning, Mr. Scott.

09:52:00 24 Q. My understanding is that  
09:52:03 25 physicians are required to take and keep  
09:52:06 26 detailed and legible notes of all  
09:52:08 27 interactions with their patients, is that  
09:52:10 28 correct?

09:52:11 29 A. Yes.

09:52:11 30 Q. And that's required by the  
09:52:13 31 College of Physicians and Surgeons is that  
09:52:15 32 correct?

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A. Correct.

Q. Is there any similar requirement for coroners to do that?

A. Coroners should document, make notes on their investigations and need to be kept for at least ten years.

Q. And so you've used the word "should", does that mean they should do it but are they required to do it?

A. It's strongly encouraged.

Q. Okay. To the best of your knowledge is it written down in a piece of legislation anywhere?

A. Not to my knowledge.

Q. Are coroners given any kind of a template to work from in order -- so a preprinted form, for example, to write their notes on?

A. There was at one point distributed a case data form which was provided to coroners, that they could use if they wished, for -- for making notes, making records for themselves. It was -- if I remember correctly, it was a while ago that it was available and I used it when I was an investigating coroner. It was developed by one of the investigating coroners as -- sorry. This was the way that I look -- you know, I documented stuff. If you want to use it go ahead and use it. So I took the liberty of using it instead of developing my 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

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1 would file both into my file for that  
2 individual case.  
3 Q. And when you are mentoring or  
4 training new coroners is that something you  
5 tell them that they should do?  
6 A. Yes.  
7 Q. And the form you talked about  
8 a few minutes ago, it sounds like that's a  
9 form you adopted that somebody else had  
10 created, is that correct?  
11 A. That is correct.  
12 Q. And do you provide that form  
13 to the 55 or so coroners in your  
14 jurisdiction?  
15 A. I do not, but I believe it is  
16 part of the package that is provided to new  
17 coroners during the educational course.  
18 Q. Thank you, sir, those are my  
19 questions?  
20 A. Thank you, sir.  
21 THE COMMISSIONER: Thank you,  
22 Mr. Scott.  
23 MS. JONES: Mr. Golden on behalf  
24 of Caressant Care.  
25 MR. GOLDEN: Good morning.  
26 THE COMMISSIONER: Good morning,  
27 Mr. Golden.  
28 CROSS-EXAMINATION BY MR. GOLDEN:  
29 Q. Dr. Mann, I take it that part  
30 of your function as the Regional Senior  
31 Coroner is to make sure that the local  
32 coroners who are working under your

09:58:21 1 jurisdiction are meeting a basic standard of  
09:58:24 2 expectation to continue on as local  
09:58:27 3 coroners?

09:58:28 4 A. Yes.

09:58:28 5 Q. And I take it that with  
09:58:29 6 respect to Dr. William George you would have  
09:58:31 7 been satisfied throughout the period of time  
09:58:34 8 that he's been a local coroner that he met  
09:58:38 9 that standard?

09:58:39 10 A. Yes.

09:58:39 11 Q. And that he had the required  
09:58:43 12 professional judgment to exercise as a  
09:58:46 13 coroner?

09:58:46 14 A. Yes.

09:58:47 15 Q. We spoke yesterday at some  
09:59:00 16 length about the term "sudden and  
09:59:01 17 unexpected" and how it's used in the IPDR  
09:59:05 18 form and in the legislation. And I'm  
09:59:06 19 curious as to whether you agree that there  
09:59:09 20 does seem to be some inconsistency in how  
09:59:13 21 people understand and interpret those words?  
09:59:15 22 Is that fair?

09:59:15 23 A. That's fair.

09:59:17 24 Q. And even within the local  
09:59:19 25 coroners there doesn't seem to be complete  
09:59:21 26 consistency in how they understand and  
09:59:23 27 interpret those words, is that fair?

09:59:26 28 A. That would be also fair.

09:59:28 29 Q. And I understood, and we  
09:59:31 30 heard this from Dr. Huyer but I believe from  
09:59:34 31 you as well, that there hasn't been any  
09:59:36 32 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 times a 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

1 coroners materials about looking for  
2 potential patterns, problems, outbreaks. Do  
3 you have a sense of whether that 1880 days  
4 works in the long-term care context?

5 A. I'm not sure I completely  
6 understand the question. If you can help me  
7 along with it I'd appreciate it.

8 Q. I'm wondering what your view  
9 is on whether 180 days is too long a time to  
10 wait for a Form 3 when it relates to a death  
11 in a long-term care home, given some of the  
12 goals that have been expressed so far in the  
13 evidence about what a coroner might learn  
14 from reviewing a death in a long-term care  
15 home?

16 A. I think that if there were  
17 some significant concerns by the coroner  
18 about what was going on in a long-term care  
19 setting there would be a telephone  
20 conversation and not necessarily waiting for  
21 the Form 3 to be complete.

22 Q. Is there any written  
23 guideline about what triggers that?

24 A. Not that I'm aware of.

25 Q. Dr. Mann, we also talked  
26 yesterday about the elimination in 2013 of  
27 the threshold investigations for long-term  
28 care?

29 A. Yes.

30 Q. And you had given some  
31 evidence about what you saw as the benefit  
32 of actually having those threshold

1 investigations. And you were also here when  
2 Dr. Huyer had indicated that in his view it  
3 was really an ineffective process. And I'm  
4 curious whether your view, from a London  
5 perspective, from this region, is that the  
6 threshold investigation is something that we  
7 should not go back to?

8 A. I think that there is some  
9 value, personally. I think that having a  
10 coroner attend to a nursing home -- or  
11 long-term care facility, I'm sorry, a  
12 long-term care facility to look at what has  
13 transpired over a period of time, allows us  
14 to see if there are any patterns that have  
15 arisen that may not have been picked up by  
16 the IPDR.

17 It may also allow us to find cases  
18 which actually should have been investigated  
19 beforehand that weren't investigated at the  
20 time, because perhaps there was some  
21 misunderstanding from the person who  
22 completed the form on some of the instances,  
23 for example. And I think I explained this  
24 yesterday as well in my testimony.

25 A fractured hip that may have  
26 occurred sometime prior to the death and --  
27 but the death appeared to the folks there,  
28 who were completing the IPDR form, that this  
29 was a natural death because they had this  
30 heart attack and we tried CPR and they died  
31 and it was a natural cause.

32 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?

1 A. Back when the decision was  
2 made I raised the concerns that I had and  
3 what happened.

4 Q. And have there been any  
5 discussions on the issue that involve  
6 regional coroners since the Wettlaufer  
7 offences have become known?

8 A. Not that I'm aware of.

9 Q. Dr. Mann, we also talked  
10 yesterday about the obligations imposed by  
11 your legislation, the Coroners Act, and in  
12 particular section 10. And as I understood  
13 it, and we talked about this with Dr. Huyer  
14 as well, section 10 requires any person who  
15 has reason to believe that a death has  
16 occurred as a result of, for example,  
17 negligence or misconduct, any person has to  
18 report that to a coroner or police?

19 A. According to the Act, yes.

20 Q. And one of the questions that  
21 I asked Dr. Huyer, I'm going to ask you as  
22 well, have you ever had such a report from  
23 the Ministry of Health or Long-Term care in  
24 relation to a death that they have become  
25 aware of in a long-term care facility?

26 A. I cannot recall that the  
27 Ministry of Health has done that but  
28 certainly under the legislation they could.

29 Q. Well, it's not just a matter  
30 of "could" I suggest it's mandatory. It  
31 says, "Small immediately notify a coroner".  
32 Is that your understanding of the

1 obligation?

2 A. That's my understanding of  
3 the obligation.

4 Q. Dr. Mann, as a regional  
5 coroner have you been involved in  
6 discussions regarding how to improve the  
7 IPDR? And I'm talking specifically since  
8 the Wettlaufer offences.

9 A. Not to my knowledge.

10 Q. And I just want to confirm,  
11 in the London region is it still the policy  
12 that if all the boxes on the IPDR are  
13 checked "no" there won't be an  
14 investigation, currently?

15 A. Currently that's correct.

16 Q. And, Dr. Mann, counsel for  
17 the Ministry asked you about what your  
18 opinion might have been had you looked at  
19 that Form 3 for Mr. Silcox? And I'm curious  
20 as to whether even with the benefit of  
21 hindsight, and keeping in mind what the  
22 practices were in place at the time, do you  
23 believe that your local coroners, had they  
24 investigated these Wettlaufer deaths, would  
25 have been live to the issue that these were  
26 homicides?

27 MS. JONES: Commissioner, I'm not  
28 sure Dr. Mann can answer that  
29 question. I think that presumes a  
30 review of the medical records of  
31 all of these patients. I think  
32 that there would have to be a

10:09:32 1 better foundation laid before  
10:09:34 2 Mr. Golden asks Dr. Mann that  
10:09:36 3 question.  
10:09:41 4 MR. GOLDEN: Well, he was asked  
10:09:43 5 about the form -- reviewing the  
10:09:44 6 form report for Mr. Silcox. And I  
10:09:47 7 don't know why it's different --  
10:09:49 8 BY MR. GOLDEN:  
10:09:49 9 Q. Have you reviewed the  
10:09:51 10 circumstances surrounding the other deaths?  
10:09:53 11 A. Can you explain what you mean  
10:09:54 12 by that?  
10:09:54 13 Q. Have you reviewed the  
10:09:56 14 circumstances surrounding the deaths of  
10:09:57 15 Ms. Wettlaufer's other victims?  
10:09:59 16 A. I have reviewed the Form 3s  
10:10:02 17 and post-mortem reports, when they were  
10:10:07 18 done, and the agreed statement of facts.  
10:10:11 19 Q. Okay. Then I'm not going to  
10:10:13 20 ask you further, thank you.  
10:10:14 21 THE COMMISSIONER: Thank you.  
10:10:16 22 Thank you, Mr. Golden.  
10:10:17 23 THE WITNESS: Thank you.  
10:10:26 24 MS. ROBINSON: Ms. Frazer on  
10:10:27 25 behalf of the Ontario Association  
10:10:28 26 of Residents Councils.  
10:10:31 27 THE COMMISSIONER: Ms. Meadus,  
10:10:32 28 thank you.  
10:10:34 29 MS. ROBINSON: Ms. Meadus, my  
10:10:35 30 apologies.  
10:10:36 31 CROSS-EXAMINATION BY MS. MEADUS:  
10:10:43 32 Q. Good morning, Dr. Mann?

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A. Morning.

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.

A. Thank you.

Q. Okay?

So I just wanted to go back. I looked 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?

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.

Q. Okay. On-the-job training?

A. On-the-job training.

Q. And another thing that you've told us is that you have one of the largest regions in southern Ontario?

A. The largest region.



1 Q. The largest region. And not  
2 knowing counties down here I did myself a  
3 map. And I understand you go down as far as  
4 Windsor, up to Tobermory, almost over to  
5 Waterloo and to Lake Erie, is that correct?

6 A. That's correct.

7 Q. So that helped me in my head  
8 because I don't know the counties well.

9 So, are the coroner evenly  
10 distributed through the area?

11 A. No.

12 Q. And do you have areas that  
13 you have staffing issues with?

14 A. Yes.

15 Q. And would those be the more  
16 rural areas? Would that be correct?

17 A. Not necessarily.

18 Q. Not necessarily? And what do  
19 you do in those areas?

20 A. We try to recruit coroners  
21 when and if we can. And we rely on the --  
22 rely on coroners that already exist to  
23 cross-cover, if possible.

24 So a coroner from Goderich, for  
25 example, may end up going up to Kincardine,  
26 or Bruce County, or somewhere else in order  
27 to do an investigation if a coroner more  
28 locally cannot be found.

29 Q. And what is the reason for  
30 having trouble finding them? Is -- do you  
31 think it's the monetary issue?

32 A. I think it is

10:13:21 1 multi-factorial. There are -- you have to  
10:13:27 2 have a bit of an interest in death  
10:13:29 3 investigation, and there is a time  
10:13:32 4 commitment. And there are certain physician  
10:13:41 5 groups where being able to commit that  
10:13:45 6 amount of time is challenging.

10:13:45 7 Because, for example, in my  
10:13:54 8 situation as a GP anesthetist when a call  
10:13:57 9 came to me when I was in the operating room I  
10:13:59 10 had to decline it because I was looking after  
10:14:05 11 the living. And, yes, the dead are important  
10:14:07 12 and I don't wish to say that they're not but  
10:14:12 13 I had another obligation to do.

10:14:16 14 There are -- you know, there are  
10:14:20 15 all sorts of other issues. Family issues,  
10:14:23 16 all sorts of other things that physicians may  
10:14:29 17 find that adding death investigation is part  
10:14:33 18 of their cadre of things that they do may be  
10:14:37 19 a little bit too much.

10:14:40 20 Q. And I wanted to now bring you  
10:14:41 21 to the process of what a coroner does. And  
10:14:45 22 we've heard about how they get a case and  
10:14:48 23 the investigation, but there are two extra  
10:14:51 24 parts that I don't think we've really heard  
10:14:53 25 about and I would just ask you to maybe  
10:14:55 26 briefly, because I don't have a lot of time  
10:14:57 27 unfortunately, just explain how does a  
10:15:00 28 case -- once an investigation has started we  
10:15:02 29 know there's the geriatric and long-term  
10:15:03 30 care review committee, how does a case get  
10:15:07 31 into that committee's sphere? How does it  
10:15:11 32 get referred there?

10:15:13 1 A. It's referred there on a  
10:15:14 2 number -- on two different reasons. One, if  
10:15:17 3 it is related to a homicide that occurs in a  
10:15:22 4 long-term care facility then it gets  
10:15:27 5 referred to the geriatric and long-term care  
10:15:32 6 committee for review. And we heard from  
10:15:35 7 Dr. Huyer that that has not happened with  
10:15:37 8 these deaths but that doesn't mean that it's  
10:15:39 9 not going to happen.

10:15:40 10 Q. Right.

10:15:41 11 A. One of the other issues is if  
10:15:43 12 the Regional Supervising Coroner, or even  
10:15:48 13 the coroner themselves, have concerns or  
10:15:52 14 issues that they feel that the expertise of  
10:15:57 15 the individuals on the geriatric and  
10:16:00 16 long-term care committee could be used to  
10:16:06 17 assist the process of the coroners  
10:16:15 18 investigation; or if there's a feeling that  
10:16:19 19 there may come recommendations from the  
10:16:23 20 geriatric and long-term care committee which  
10:16:26 21 could be used -- which could be provided to  
10:16:29 22 either the long-term care facility itself,  
10:16:33 23 if it is a sort of an isolated problem, or  
10:16:39 24 to the broader community of long-term care  
10:16:42 25 facilities, if there is a feeling that it  
10:16:45 26 perhaps is a more global issue.

10:16:49 27 Q. Okay. Thank you.

10:16:50 28 And is there a similar process for  
10:16:52 29 inquests? So we know there's some mandatory  
10:16:55 30 inquests but there's also discretionary ones,  
10:16:58 31 would it be a similar kind of process to call  
10:17:01 32 an inquest into a death?

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A. Yes.

Q. Okay. Thank you very much.

I would like to now bring up our document 71445, which is Exhibit G in your affidavit. And just while they're bringing that up -- so this is the death of Wayne Hedges who was -- he was reviewed as a threshold case. And I understand that while you were Regional Supervising Coroner at the time you did not review this case. This was a case that I believe you were aware for?

A. One of my colleagues --

Q. And Dr. Lucas I believe did the review?

A. That's right.

Q. Can you go down to next page please? I seem to have put down the wrong number here. Let's try this again. Let's try 64920, sorry, which is Exhibit K.

So this is for Wayne Hedges. And can you just scroll down a little bit please to page 2? And so this would be an example of what the review would look like, is that correct? They would note up on the document, I would assume those are Dr. Lucas' notations, is that correct?

A. The --

Q. In the pen.

A. In the presumably pen, yes.

Q. And can you go down a little bit farther please? So this is just more of some issues around capitalization and that

1 sort of thing, is that correct?

2 A. Yes.

3 Q. Okay. So we get to the  
4 narrative and in that it says that this was  
5 a threshold death; there was a finding that  
6 it was felt that he had a cerebral vascular  
7 accident. Is that correct?

8 A. Yes.

9 Q. Okay. And then this would  
10 have been reviewed. And my understanding is  
11 that this would be all that the coroner  
12 would review? You wouldn't look at -- or  
13 the regional supervisor would review. You  
14 wouldn't look at the -- the records at the  
15 home, is that correct?

16 A. That's correct.

17 Q. And would you speak to the  
18 coroner or would you only do that if you had  
19 questions?

20 A. I can't say what Dr. Lucas'  
21 practice was. My practice was if I had  
22 concerns I would speak to coroner but  
23 otherwise I would not.

24 Q. And at the bottom it says,  
25 "Family had no concerns." Do you see that?

26 A. I do.

27 Q. So I'm going to ask you to  
28 bring up document 43003, and these are  
29 notes, and this is in Exhibit 9 and these  
30 are supporting documents to that exhibit,  
31 which we will hear from the Ministry later.  
32 So can we go to page 42?

1 And this is a document you will not  
2 have seen. And so these are -- I'm expecting  
3 we're going to hear from Ms. Kukoly, who is  
4 from the Ministry of Health, and she's one of  
5 the inspectors.

6 And she's a sister of -- the sister  
7 of Wayne Hedges was being interviewed. I'm  
8 going to provide this, this is already an  
9 exhibit but I'm going to provide you with  
10 these documents just for assistance.

11 THE COMMISSIONER: Thank you.

12 I think we should enter it now  
13 because otherwise anyone trying to  
14 follow the Webcast will be unable  
15 to have access to it. If we do  
16 that it will go up shortly.

17 MR. GOLDEN: My suggestion would  
18 be we enter it for identification  
19 because it's double, triple  
20 hearsay. We don't know what  
21 Ms. Kukoly is going to say.

22 THE COMMISSIONER: All right. I  
23 think that's exactly right. So it  
24 is a lettered exhibit. And Madam  
25 Clerk, can you help me with this.  
26 I have been trying to keep all the  
27 lettered exhibits so we can sort  
28 this out afterwards. I think that  
29 we have only three lettered  
30 exhibits so far. Is that -- I  
31 don't know if you've been keeping  
32 track of it?

10:21:51 1 THE CLERK: I have, I'm just going  
10:21:52 2 to pull that up. Our next letters  
10:22:00 3 exhibit would be F I believe.

10:22:03 4 THE COMMISSIONER: Okay. So we'll  
10:22:04 5 call this Exhibit F for the  
10:22:06 6 purposes of identification. Just  
10:22:08 7 to be clear for everyone, the  
10:22:11 8 letters exhibits will not be  
10:22:13 9 placed on the website.

10:11:42 10 EXHIBIT NO. F: Marked for  
10:11:42 11 identification, document 43003.

10:22:21 12 BY MS. MEADUS:

10:22:21 13 Q. Can you scroll down a little  
10:22:22 14 bit please?

10:22:24 15 So this is an interview that they  
10:22:26 16 did when they were doing the review, the  
10:22:30 17 inspection of the home following the deaths,  
10:22:32 18 okay? And this is an interview of the sister  
10:22:35 19 of Mr. Hedges. So we can go along a little  
10:22:37 20 bit further please.

10:22:39 21 So they asked a number of questions  
10:22:47 22 about Mr. Hedges. So right here it says the  
10:22:54 23 time is 1:54, and at that point in time the  
10:22:57 24 interviewer said -- asked her if there  
10:22:58 25 anything else you would like to add? And I'm  
10:23:01 26 just going to review a little bit about what  
10:23:01 27 she had to say.

10:23:01 28 "Can I ask you a question? Of  
10:23:09 29 course you can. I don't know if  
10:23:11 30 this is anything you can tell me or  
10:23:13 31 if I have to wait. We're going to  
10:23:15 32 see the Crown attorney in a couple

10:23:17 1 of days. Why weren't we getting  
10:23:19 2 any answers from Caressant Care  
10:23:20 3 when he passed a way? Mom and dad  
10:23:22 4 tried and tried to get answers as  
10:23:24 5 to what happened and they would not  
10:23:25 6 tell them anything, and they  
10:23:25 7 referred them to coroners office  
10:23:27 8 and the coroners office had no  
10:23:28 9 answers."  
10:23:31 10 So a little bit farther down it  
10:23:33 11 says, it was a question:  
10:23:34 12 "So your mom and dad were looking  
10:23:36 13 for answers before and after he  
10:23:38 14 passed away about his condition?"  
10:23:40 15 And his sister says:  
10:23:42 16 "They called about 1 o'clock in  
10:23:44 17 morning or something and said he  
10:23:45 18 passed away. And they tried for --  
10:23:46 19 I bet they tried for months to find  
10:23:48 20 out, to find out why he passed  
10:23:49 21 away. So to this day we still  
10:23:51 22 really don't know why he passed  
10:23:53 23 away."  
10:23:53 24 And the questioner say:  
10:23:55 25 "Did they talk to the doctor at  
10:23:57 26 all? I don't know who they talked  
10:23:59 27 to so I would imagine they did  
10:24:01 28 because they tried every route  
10:24:03 29 they could think of to find out  
10:24:05 30 what was going on and nobody could  
10:24:07 31 tell us anything. So I'm hoping  
10:24:08 32 that maybe we can go up on the 6th



10:24:09 1 actually to the Courthouse to talk  
10:24:11 2 to prosecutors office. I'm hoping  
10:24:13 3 we can get answers then. I don't  
10:24:14 4 know if we will or not."  
10:24:16 5 And then there's a question:  
10:24:17 6 "And they told you to call the  
10:24:18 7 coroners office."  
10:24:18 8 And the answer is:  
10:24:20 9 "That's what my mom had said. They  
10:24:22 10 said, well contact the coroners  
10:24:23 11 office. Unless there was an  
10:24:25 12 autopsy done there wouldn't be any  
10:24:26 13 reason for the coroner to be  
10:24:28 14 involved."  
10:24:28 15 And then the question i:  
10:24:29 16 "So to your knowledge the coroner  
10:24:32 17 wasn't involved in his death?"  
10:24:33 18 And the answer was:  
10:24:34 19 "Not to my knowledge because there  
10:24:36 20 was never an autopsy done or  
10:24:37 21 anything. At least if there was we  
10:24:40 22 weren't told there was."  
10:24:42 23 So it would appear that there were  
10:24:43 24 concerns in this family about the death and  
10:24:45 25 that was not reflected on the document.  
10:24:47 26 Would you agree from this information, from  
10:24:50 27 this information.  
10:24:51 28 MS. BAMBERS: Well, I'm just  
10:24:52 29 concerned about how the question  
10:24:53 30 is phrased, Commissioner, because  
10:24:55 31 this is really kind of triple  
10:25:00 32 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.

1 Q. And they don't know the  
2 difference between an investigation and  
3 having an autopsy; is that correct?

4 A. That would be a fair  
5 statement.

6 Q. And from this kind of a  
7 comment would you agree that it might be  
8 helpful, especially in long-term care, to  
9 have some kind of information package from  
10 the coroners office explaining what the role  
11 was, that could perhaps be given to families  
12 so that they understood? And giving them  
13 information about what they might ask if  
14 they had questions?

15 A. The coroners office had -- at  
16 that time had a pamphlet to that coroners  
17 could provide to families with regards to  
18 what a coroner is, what a coroners  
19 investigation does and had a place on it for  
20 the coroner to put their contact information  
21 on the form, or on the pamphlet, so that the  
22 family could contact the coroner if they had  
23 any questions or concerns.

24 Subsequently we have developed a  
25 booklet, that's bilingual, that also has all  
26 the information that the coroners can provide  
27 to families at the time of first contact.  
28 And, again, it has a place for the coroner to  
29 put their contact information on it so that  
30 the families can contact the coroner. And it  
31 also has on it the -- the regional coroners  
32 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 1 Meadus .

10:30:45 2 MS. MEADUS: Thank you.

10:30:51 3 MS. ROBINSON: Ms. Butt on behalf

10:30:53 4 of the Ontario Nurses Association.

10:30:55 5 MS. BUTT: ONA has no questions.

10:30:58 6 THE COMMISSIONER: Thank you.

10:31:02 7 MS. ROBINSON: Ms.

10:31:02 8 Schwartzentruber on behalf of the

10:31:04 9 College of Nurses.

10:31:11 10 MS. SCHWARTZENTRUBER: College of

10:31:11 11 Nurses has no questions for this

10:31:12 12 witness.

10:31:12 13 THE COMMISSIONER: Thank you.

10:31:12 14 MS. ROBINSON: Mr. Schwartz on

10:31:12 15 behalf of AdvantAge Ontario.

10:31:15 16 MR. SCHWARTZ: AdvantAge Ontario

10:31:16 17 has no questions for this witness.

10:31:19 18 MS. ROBINSON: In that case

10:31:20 19 Ms. Bambers on behalf of the

10:31:22 20 Province.

10:31:27 21 RE-EXAMINATION BY MR. BAMBERS:

10:31:34 22 Q. Just one question, Dr. Mann,

10:31:35 23 you mentioned that to date there has been no

10:31:39 24 tracking of trends or patterns on the case

10:31:43 25 selection forms, correct?

10:31:46 26 A. Not to my knowledge.

10:31:47 27 Q. And as it stands now it would

10:31:52 28 require going through each paper and

10:31:54 29 identifying the trends because it's not

10:31:56 30 computerized?

10:31:57 31 A. That's correct.

10:31:58 32 Q. And that would be much easier

1 to do if it was computerized?

2 A. And I think, as Dr. Huyer was  
3 mentioning in his testimony, we are -- we're  
4 moving to a more robust and computer-based  
5 system so that once we get there there would  
6 be the possibility of being able to do some  
7 of that tracking and searching.

8 Q. Thank you. Those are all my  
9 questions.

10 A. Thank you.

11 THE COMMISSIONER: Thank you very  
12 much.

13 MS. ROBINSON: We have no further  
14 re-examination for Dr. Mann.

15 THE COMMISSIONER: Thank you very  
16 much. Dr. Mann, thank you so  
17 much. You're free to go. We very  
18 much appreciate your time.

19 THE WITNESS: Thank you. Thank  
20 you, Madam Commissioner,  
21 appreciate the opportunity.

22 MS. JONES: Morning Commissioner.

23 THE COMMISSIONER: Morning.

24 MS. JONES: We've passed up a  
25 document brief which we'll be  
26 using for the next two witnesses.  
27 And if I can now call Dr. William  
28 George please?

29 DR. WILLIAM GEORGE: SWORN

30 EXAMINATION IN-CHIEF BY MS. JONES:

31 THE COMMISSIONER: Morning,

32 Dr. George, you sound like a very

10:34:46 1 soft spoken person so I will  
10:34:48 2 encourage you to try to keep your  
10:34:50 3 voice up. The transcriptionist  
10:34:53 4 will still need to hear you.  
10:34:55 5 Thank you so much.  
10:34:56 6 THE WITNESS: All right.  
10:34:59 7 BY MS. JONES:  
10:35:00 8 Q. Morning, Dr. George.  
10:35:02 9 A. Morning.  
10:35:02 10 MS. JONES: And I note for the  
10:35:03 11 benefit of the Commissioner that  
10:35:05 12 Dr. George's co-counsel,  
10:35:05 13 Mr. Hubbard, has joined us as  
10:35:08 14 counsel table.  
10:35:10 15 THE COMMISSIONER: Morning, Mr.  
10:35:10 16 Hubbard.  
10:35:11 17 BY MS. JONES:  
10:35:11 18 Q. Dr. George, I'm going to  
10:35:12 19 begin by asking you some questions about  
10:35:13 20 your background. And you should have in  
10:35:15 21 front of you a document brief. I'm going to  
10:35:18 22 ask you to turn to tab 1 of that brief.  
10:35:25 23 A. Okay.  
10:35:25 24 Q. And is this your curriculum  
10:35:27 25 vitae?  
10:35:28 26 A. Yes, it is.  
10:35:29 27 Q. And it is an accurate summary  
10:35:30 28 of your education and work experience?  
10:35:32 29 A. It is a brief summary.  
10:35:34 30 Q. And if we can mark  
10:35:35 31 Dr. George's curriculum vitae as the next  
10:35:38 32 exhibit.



10:35:44 1 THE COMMISSIONER: So currently it  
10:35:45 2 is 72831 in the documents?  
10:35:49 3 MS. JONES: That's right, but it's  
10:35:50 4 not yet an exhibit, Commissioner.  
10:35:51 5 THE COMMISSIONER: Okay.  
10:35:51 6 MS. JONES: And if we can pull  
10:35:52 7 that up as well it's document  
10:35:55 8 72831.  
10:35:56 9 THE COMMISSIONER: So, Madam  
10:35:56 10 Clerk, if I'm right that's Exhibit  
10:35:57 11 106.  
10:35:57 12 THE CLERK: That's right.  
10:35:57 13 THE COMMISSIONER: So Exhibit 106,  
10:35:57 14 a single page summary of  
10:35:57 15 Dr. George's resume.  
10:36:01 16 EXHIBIT NO. 106: Summary of  
10:36:09 17 Dr. George's resume, document  
10:36:12 18 72831.  
10:36:27 19 BY MS. JONES:  
10:36:27 20 Q. Dr. George, you are a  
10:36:28 21 physician, correct?  
10:36:29 22 A. Yes.  
10:36:29 23 Q. And you have practiced  
10:36:31 24 medicine in Ontario since 1989?  
10:36:36 25 A. Yes, that's correct.  
10:36:38 26 Q. And I understand from your  
10:36:40 27 curriculum vitae that you graduated from  
10:36:42 28 medical school in Bulgaria in 1986?  
10:36:47 29 A. That's correct.  
10:36:47 30 Q. And you then did a rotating  
10:36:49 31 internship in Saskatchewan, for a year?  
10:36:53 32 A. That's correct.

1 Q. And following that you did a  
2 year of internal medicine residency at  
3 Sunnybrook Hospital in Toronto?

4 A. That's correct.

5 Q. And I also understand, if we  
6 look at your education, that in 1994 after  
7 you had begun practicing medicine you did  
8 return to school and do some postgraduate  
9 training in anaesthesia?

10 A. That is correct.

11 Q. Most recently in the year  
12 2017 you completed further education this  
13 time in practical dermatology?

14 A. That's correct.

15 Q. Now in terms of your work  
16 experience, if we look at your curriculum  
17 vitae and we scroll down a little bit on the  
18 page, the third point under your work  
19 experience provides that between 1987 and  
20 1992 you practiced as a general duty medical  
21 officer and flight surgeon in the Canadian  
22 Armed Forces?

23 A. That's correct.

24 Q. And there you held the rank  
25 of Captain in the Air Force?

26 A. Yes.

27 Q. And we also learned under  
28 your work experience that in 1994 you moved  
29 to Woodstock where you started a private  
30 practice?

31 A. That is correct.

32 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?

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A. Yes it does.

Q. And how do you divide your time between those elements of your practice?

A. Two day a week I'm in the operating room; three days a week, Tuesday, Wednesday and Friday I'm in my office; I also have a nurse practitioner; and the civil aviation and dermatology components are added on to that. We also provide a little bit of after-hours services through our office as well.

Q. And is that a full-time practice between all of those responsibilities?

A. Yes.

Q. And in terms of your private practice am I correct that it's part of a family health team?

A. Yes.

Q. And as part of your family health team practice are any of your patients in long-term care homes?

A. Yes.

Q. And how does that work in terms of seeing patients that are in long-term care homes? Do you have certain days on which you go and visit them?

A. At any given time I probably have about four or five patients that are in one of the three nursing homes in Woodstock and I usually try and get to see them once

1 every couple of months.

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

4 A. Yes, I have.

5 Q. And what about Meadow Park or  
6 Telfer Place?

7 A. No.

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

11 A. That's correct.

12 Q. And when did you become a  
13 coroner?

14 A. 2004.

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

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

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

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

29 A. That's correct.

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

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in Bulgaria?

A. That's correct.

Q. And is it your understanding that that sort of forensic medicine training is standard in our universities and medical schools in Ontario?

A. I'm not sure that it is.

Q. After you did the new coroners course did you receive any other course-based training before you started to work as a coroner in Ontario?

A. No. There was no course after that, there was a mentorship period.

Q. And can you describe the mentorship please?

A. At the time the regional coroner was out in Guelph, Dr. Acheson, and I was to call with each case that I had and discuss with her each situation no matter what time of day it was.

Q. And were you to call her at the point of deciding whether or not to do a death investigation or only once you had decided to do a death investigation?

A. Either.

Q. Either, okay. And do you have any recollection now about how long a period of time that period of mentorship was?

A. Six months.

Q. And when you say you were to call the Regional Supervising Coroner were

10:42:47 1 there certain points throughout the process  
10:42:49 2 of deciding whether to do an investigation  
10:42:51 3 and conducting a death investigation that  
10:42:53 4 you were to check in with the Regional  
10:42:54 5 Supervising Coroner as part of your  
10:42:57 6 training?

10:42:57 7 A. Yes, I'd usually call her to  
10:42:59 8 start with and then she'd want to speak to  
10:43:03 9 me later about what I thought about the case  
10:43:04 10 and how I was going to put it together.

10:43:07 11 Q. Did you find the mentorship  
10:43:10 12 to be a helpful process?

10:43:11 13 A. Very helpful.

10:43:12 14 Q. And did you, when you  
10:43:13 15 started -- when you had done your course and  
10:43:15 16 you had started -- you had completed your  
10:43:18 17 mentorship did you feel you were  
10:43:21 18 appropriately prepared to work as a coroner?

10:43:23 19 A. I felt so. I always had the  
10:43:25 20 option of calling her in any kind of  
10:43:28 21 situation.

10:43:29 22 Q. Is it your understanding that  
10:43:33 23 once you become a coroner and you go through  
10:43:35 24 the mentorship and the new coroners course,  
10:43:39 25 is it your understanding that there's any  
10:43:41 26 further mandatory training that you're  
10:43:43 27 required to do to maintain your coroners  
10:43:46 28 status?

10:43:47 29 A. I'm not sure if it was  
10:43:48 30 mandatory but we were to attend the courses  
10:43:52 31 held every year by the coroners office every  
10:43:56 32 other year.

1 Q. So your understanding was the  
2 expectation was to go to the annual coroners  
3 course every two years?

4 A. Every other year.

5 Q. And did you do that?

6 A. I believe so.

7 Q. And we heard evidence earlier  
8 that at a certain point that rotating every  
9 year or every few years system changed to a  
10 system where coroners were invited to come  
11 every year if they chose to?

12 A. That's correct.

13 Q. And have you been attending  
14 the annual coroners course since that  
15 change?

16 A. Yes, the last one I attended  
17 was last November.

18 Q. Other than the new -- sorry,  
19 the annual coroners course do you attend  
20 other coroner training?

21 A. Not formally.

22 Q. And today, now that you are  
23 an experienced coroner, do you have any  
24 ongoing mentorship by your Regional  
25 Supervising Coroner?

26 A. The regional coroner is  
27 always available by telephone and is always  
28 ready to help. Even on-call when you call  
29 somebody you usually get somebody on the  
30 other end and you can have a discussion and  
31 that can help you through a difficult  
32 situation.



1 Q. And Dr. Mann has given  
2 evidence that on occasion he'll review a  
3 Form 3 and have questions about it and call  
4 the local coroner. Have you been the  
5 recipient of that sort of feedback on your  
6 Form 3s?

7 A. Occasionally.

8 Q. We've also heard evidence  
9 over the last couple of days, Dr. George,  
10 from Dr. Huyer about certain memos and best  
11 practice guidelines issued from his office.  
12 You're familiar with those documents?

13 A. Yes.

14 Q. And do you receive those  
15 documents in some way over the course of  
16 your practice?

17 A. Yes, we receive them  
18 electronically. We used to receive them in  
19 the mail and they used to go into a big  
20 binder.

21 Q. And now that you receive them  
22 electronically what's your practice?

23 A. I save them as a PDF file.

24 Q. Do you review them?

25 A. Yes.

26 Q. And after you review them and  
27 you save them do you have occasion to  
28 reference them or refer to them?

29 A. Occasionally.

30 Q. And we've also heard evidence  
31 about a Coroners Investigation Manual, and  
32 as part of that Manual guidelines for death

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

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service in London?

A. That's correct.

Q. But since that time when you get contacted about a death you would be contacted through provincial dispatch?

A. Through central dispatch, yes.

Q. Central dispatch. But that's a provincial service?

A. Yes.

Q. And I want you to walk us through the process of receiving the call and determining whether or not to conduct a death investigation. So, first, approximately how many calls would you receive from provincial dispatch on a monthly basis?

A. Perhaps seven or eight calls, maybe as many as 10 call as month.

Q. And has that number stayed relatively consistent since 2004? Has it gone up? Has it gone down?

A. It varies widely. You could be very busy one week and not have a call for several weeks.

Q. And are you, in your region, on a call schedule or could you get calls at any time?

A. We're on a -- we could get calls ate at any time. I believe that the central dispatch goes through a -- they go through people.

1 Q. When you get a call from  
2 provincial dispatch reporting on a death  
3 what information do you receive?

4 A. Usually central dispatch will  
5 call, and if it's in the middle of the night  
6 I'll get up and go into the room where  
7 there's a desk and put my glasses on,  
8 because I can't see, and then I'll make some  
9 notes.

10 And usually central dispatch will  
11 provide a synopsis of what's occurred and  
12 provide some telephone numbers, a telephone  
13 number and a contact number.

14 Q. And the contact number is for  
15 who?

16 A. Maybe for the police, it may  
17 be the hospital, it may be long-term care  
18 facility.

19 Q. And if it's a long-term care  
20 facility who's typically the contact?

21 A. Typically if it's after hours  
22 you would be put through to the ward where  
23 the death has occurred. So it would be the  
24 RN that would be on -- that would be taking  
25 the call.

26 Q. And when you receive these  
27 calls from provincial dispatch are there  
28 ever occasions where you advise provincial  
29 dispatch that you're not going to take the  
30 case? And I don't mean you've weighed it  
31 and decided on a death investigation, but  
32 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

1 from provincial dispatch and you can't  
2 immediately determine whether or not it's a  
3 coroner's case do you go through a process  
4 to make that determination about whether or  
5 not a death investigation is warranted under  
6 the Act?

7 A. Absolutely.

8 Q. And so what do you do? So  
9 you get the call from provincial dispatch,  
10 what's your next step?

11 A. They would provide me with a  
12 name and the date of birth; and then a lot  
13 of times from home I can simply access the  
14 files, the medical records electronically  
15 from the hospital and glean it information  
16 from there, which is usually very useful.

17 Q. Obtaining the medical records  
18 from the hospital?

19 A. From the hospital or from --  
20 because we're in a family health team I have  
21 access to all of the records as well. So we  
22 can pull up somebody's records quite  
23 quickly.

24 Q. Do you have access to that --  
25 those sorts of records in the long-term care  
26 home context?

27 A. No, we don't.

28 Q. So you're provided with a  
29 contact information, and let's take the  
30 long-term care home context. You don't have  
31 access to the medical records. What do you  
32 do next? Do you call the contact person?

1 A. I would call the contact  
2 person.

3 Q. And can you walk me through  
4 what questions you asked the contact person?

5 A. I would, you know, call the  
6 contact person and ask, you know, what the  
7 situation is. And most often they would  
8 give you a brief summary of what had  
9 occurred and, you know, what the situation  
10 was and that kind of thing.

11 And then if I needed more  
12 information then I would, you know, probably  
13 look for more information on-line through the  
14 Cerner system or through our EMR to find out  
15 if I can see anything else on the patient if  
16 they've been to hospital, et cetera.

17 Q. So if I understand your  
18 evidence correctly, in the long-term care  
19 home context you wouldn't have access to  
20 long-term care home records at that stage?

21 A. No.

22 Q. But you might look to see if  
23 you could access other either hospital  
24 records or family health team records?

25 A. Yeah, a visit to the hospital  
26 and that way I can get a summary of their  
27 medications. I can get that from the  
28 nursing home as well because they can read  
29 it off the medication summary.

30 Q. Do you think it would be  
31 helpful if you could access to long-term  
32 care home records directly at this stage?

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A. It would be helpful.

Q. You started to describe your conversation with the contact person, that you asked them about the circumstances of the death. Do you ask them about the patient's medical history.

A. Yes, the patient's medical history: How long they've been there? What their previous level of functioning was? What their co-morbidities are? That kind of thing. Whether anything else is happening at the nursing home? Whether they're in the midst of an outbreak? Or that kind of thing.

Q. At this stage when you're having this initial discussion with the contact person do you have the Institutional Patient Death Record?

A. When I'm on the telephone?

Q. Yes.

A. No.

Q. So how do you determine why you've been called in terms of what boxes have been checked "yes" on that Institutional Patient Death Record?

A. I have the -- a case selection form that's pinned to my bulletin board in front of my desk and I go through the elimination --

Q. Before we get there, Dr. George, before we get to the case -- and I do want to hear about that, but my



1 question is, taking a step back, you don't  
2 have the IPDR in front of you, correct?

3 A. Right, I would ask the nurse  
4 if there were anything checked off that was  
5 of concern.

6 Q. Okay.

7 A. I'm sorry.

8 Q. That's all right. So you  
9 would ask the nurse, What did you check off  
10 on the IPDR?

11 A. That's right.

12 Q. And what are you trying to  
13 determine at this initial stage when you're  
14 speaking to the contact person? What  
15 assessment are you making?

16 A. We're trying to determine if  
17 the case is a coroners case, warrants  
18 furthers investigation or not.

19 Q. And in a long-term care home  
20 context what's typically the decision point  
21 on that in terms of whether or not it's a  
22 coroners case?

23 A. Whether the death was  
24 accidental; whether there are any kind of  
25 unusual circumstances; whether there's an  
26 outbreak; whether there's an infectious  
27 outbreak going on.

28 Q. Now, other than the  
29 contact -- speaking to the contact person  
30 and looking at the records, as you've  
31 described, do you typically speak to anyone  
32 else at this assessment stage?

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A. Not usually.

Q. Do you ever speak to the family at this stage if they're not the contact person?

A. No.

Q. And what about treating physicians? Do you ever speak to treating physicians at this stage?

A. Yes.

Q. And under what circumstances would you do that?

A. If there was some concerns from the treating physician. Sometimes in a nursing home the treating physician may have initiated the call to central dispatch.

Q. When determining, again at this assessment stage, whether or not to conduct a death investigation do you have to decide in some cases whether or not in your view a death was sudden and unexpected?

A. Yes, that is one of the questions.

Q. And in the context of a death in a long-term care home what does "sudden and unexpected" mean to you?

A. I'm not sure that the term "sudden and unexpected" in a nursing home is entirely appropriate. I think a death can be sudden but it may have been foreseeable or expected.

Many of these unfortunate people 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

1 example for an elderly person with  
2 co-morbidities where the death would be  
3 sudden and unexpected or not foreseeable?

4 A. If, for example, they were  
5 assaulted by another patient.

6 Q. Do you consider -- during  
7 this assessment phase do you consider the  
8 manner in which the patient died? Or do you  
9 obtain information about that? So not just  
10 that the patient passed away and what their  
11 co-morbidities were, but also in their final  
12 stages or their final days of life what  
13 their condition was?

14 A. Yes. I usually ask, What  
15 were the conditions surrounding their final  
16 illness or the final days to get some sort  
17 of an idea of what had gone on.

18 Q. And why is that important?

19 A. Because that can tell us  
20 whether there was something going on and the  
21 death was expected or, you know, something  
22 serious was going on.

23 Q. Now, you referenced the Case  
24 Selection Data Form, and perhaps we can turn  
25 that up. That's at tab 21 of your document  
26 brief and it's document 71436.

27 Dr. George, I believe you were  
28 beginning to tell me about your process with  
29 this Case Selection Data Form when I  
30 interrupted you.

31 So now again we're staying with the  
32 assessment phase, before you've decided

11:00:52 1 whether or not to do a death investigation.  
11:00:54 2 Does this form, the Case Selection Data Form,  
11:00:55 3 play any role in your assessment?

11:00:58 4 A. Yes. I keep it in front of  
11:01:00 5 me on the wall, on my bulletin board and I  
11:01:05 6 reference that while I'm speaking to whoever  
11:01:07 7 is on the telephone.

11:01:09 8 Q. And when you say you  
11:01:11 9 "reference" it do you complete it?

11:01:14 10 A. Not usually. I'm not in the  
11:01:19 11 habit of completing it.

11:01:20 12 Q. And we see that the  
11:01:22 13 question -- question number 2 on this Case  
11:01:25 14 Selection Data Form refers to whether the  
11:01:27 15 death was reasonably foreseeable? Is that,  
11:01:31 16 in your view, a different way of looking at  
11:01:34 17 sudden and unexpected or is that a different  
11:01:36 18 question?

11:01:37 19 A. I think that that's a better  
11:01:41 20 question.

11:01:42 21 Q. Why is that?

11:01:43 22 A. Because it says:  
11:01:45 23 "Was the death reasonably  
11:01:47 24 foreseeable and does the cause flow  
11:01:49 25 logically from a natural disease  
11:01:51 26 process."

11:01:53 27 So it's a lot easier to put things  
11:01:56 28 together in that kind of a light.

11:01:57 29 Q. Now, you've testified that it  
11:02:02 30 is not your practice to complete the Case  
11:02:05 31 Selection Data form. Is it your  
11:02:10 32 understanding that the completion of this

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

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A. Yes.

Q. And if we turn now to page 7 -- well actually let's start at page 6. Under "Procedure" it refers to -- there's two documents, there's the Case Selection Data Form and then there's the case selection invoice. And then it says under that:

"The Case Selection Data Form will facilitate collection of data to ensure the case and decisions can be reviewed."

Right?

A. That's correct.

Q. And then if you turn over to page 7? Under "Concluding Remarks" now there's a paragraph which outlines the anticipated benefits that will arise from the submission of the Case Selection Data Form and it says:

"First, coroners will receive guidance about what criteria should be considered."

So that's the first benefit. And were you receiving guidance from this form in making your assessment decisions?

A. Guidance from whom?

Q. The Case Selection Data Form itself?

A. Yes, I was using it.

Q. Okay. And it says, "Second", and looking at second and third at the same

11:05:03 1 time:  
11:05:03 2 "Secondly, uniformity in approach  
11:05:06 3 across the Province will be  
11:05:08 4 achieved; and, thirdly, an added  
11:05:10 5 level of oversight will be achieved  
11:05:12 6 by a careful review of the form."  
11:05:16 7 And did you appreciate that those  
11:05:18 8 were also goals of the case selection data  
11:05:22 9 form?  
11:05:22 10 A. Yes.  
11:05:22 11 Q. Okay. And, fourth, as you  
11:05:25 12 mentioned, that coroners will be  
11:05:28 13 compensated, which is the -- your  
11:05:31 14 understanding that you expressed earlier?  
11:05:33 15 A. Which was the main reason  
11:05:34 16 that I thought that this was brought in.  
11:05:36 17 Q. But now looking at these  
11:05:39 18 concluding remarks, and the goals of the  
11:05:43 19 Case Selection Data Form, do you have any  
11:05:45 20 intention in terms of using this form and  
11:05:48 21 submitting this form when doing case  
11:05:50 22 assessments going forward?  
11:05:52 23 A. Going forward, yes,  
11:05:53 24 absolutely.  
11:05:53 25 Q. Do you think it's a helpful  
11:05:55 26 process?  
11:05:55 27 A. I think so.  
11:06:03 28 Q. Now, when you weren't -- you  
11:06:09 29 weren't recording anything on the Case  
11:06:10 30 Selection Form and submitting it, were you  
11:06:14 31 otherwise recording notes during the  
11:06:16 32 assessment process?



1 A. Yes. I usually had a pad and  
2 paper and I was making notes on the paper.  
3 Unfortunately I didn't maintain those  
4 records for any significant length of time  
5 when it wasn't a coroner's case.

6 Q. So just to unpack that, you  
7 would take notes while you were having your  
8 discussions with dispatch?

9 A. While I was having a  
10 discussion with dispatch; while I was  
11 then -- when I would call and find out more  
12 information about the case, whether or not  
13 it was a coroner's case or not, the  
14 circumstances surrounding the death. I  
15 would be making notes about that. I may  
16 even check and call and find out more  
17 information.

18 Q. Okay. And then if you  
19 determined that the case was not a coroner's  
20 case, did not meet the criteria for a  
21 coroner's case what did you do with those  
22 notes?

23 A. I didn't maintain them. I  
24 kept them for a while but then disposed of  
25 them.

26 Q. And when you say "for a  
27 while" can you give me an idea of what that  
28 means?

29 A. Probably for a couple of  
30 weeks.

31 Q. And then you would dispose of  
32 them?

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A. Yeah.

Q. And we've heard evidence from Dr. Huyer that from his perspective the maintenance of notes, even when you rejected a death -- let me use a different word, even when you determined that a death investigation was not warranted, that the maintenance of notes was considered mandatory by the Office of the Chief Coroner. Did you appreciate that?

A. Not fully. It's because I felt that, you know, those -- that information could be obtained from central dispatch and from the medical records either at the nursing home, or through the hospital, or the patient private records.

Q. Okay. So -- and I guess is it -- to clarify your evidence, you're giving reasons why perhaps in your view the maintenance of notes wasn't important?

A. That's right. I didn't actually see the patient.

Q. Okay, fair enough. But did you have an understanding that from the Office of the Chief Coroners view, and I can take you -- and perhaps we should do that, if I can take you to tab 24. And this is document 72826.

And, Dr. George, this document is part of the Coroners Investigation Manual. This particular document we see the date at the bottom June 2013, and there's been

1 evidence that it was the document in place  
2 between June 2013 and June 2014. Does that  
3 make sense to you?

4 A. That's correct.

5 Q. And if you turn now to page  
6 11 in this document and you go under  
7 "Reporting" please?

8 A. That's correct.

9 Q. And this document states  
10 that:

11 "All cases reported to a coroner,  
12 even those that the coroner  
13 determines do not require a  
14 coroners investigation should be  
15 documented in a retrievable and a  
16 reviewable manner by the coroner."  
17 Do you see that?

18 A. Yes.

19 Q. And the next paragraph says:  
20 "For cases declined for  
21 investigation, coroners should make  
22 and keep a brief record for their  
23 own use, with the potential for  
24 future review detailing the date,  
25 name of the deceased, name of the  
26 reporting person and sufficient  
27 information to identify the case,  
28 and indicating why it did not  
29 require a coroners investigation."

30 A. Yes.

31 Q. And as part of your practice  
32 would this have been a document that you

1 were familiar with?

2 A. Yes.

3 Q. So now having looked at that  
4 document, and again just now taking a step  
5 back, did you appreciate or do you now  
6 appreciate that the maintenance of notes was  
7 mandatory whether or not you accepted a case  
8 for investigation?

9 A. Yes, I realize now that that  
10 should have -- those records should have  
11 been kept.

12 Q. Fair enough. And going  
13 forward is that your intention?

14 A. Absolutely.

15 Q. Now, you've testified that  
16 you received seven to eight calls from  
17 provincial dispatch roughly a month, and of  
18 those calls can you give us a sense of how  
19 many then resulted in a death investigation  
20 that you personally would conduct as opposed  
21 to saying you weren't available to do it?

22 A. Probably three or four a  
23 month.

24 Q. And in your view is that a  
25 sufficient number of death investigations to  
26 maintain your skills as a coroner?

27 A. I think so, yes.

28 Q. I'm going to ask you some  
29 questions now about accepting cases for  
30 death investigations in the long-term care  
31 home context.

32 So, first, when was the last death

11:11:42 1 investigation you did in a long-term care  
11:11:44 2 home?

11:11:45 3 A. I can't recall.

11:11:46 4 Q. Can you give us a sense? Is  
11:11:47 5 it a matter of months or years?

11:11:50 6 A. I think it's years.

11:11:55 7 Q. And was there a certain point  
11:11:57 8 where you stopped doing as many death  
11:12:00 9 investigations in long-term care homes?

11:12:02 10 A. That was in 2013.

11:12:05 11 Q. And what was that the result  
11:12:06 12 of?

11:12:06 13 A. They did away with the  
11:12:09 14 investigation of threshold cases.

11:12:12 15 Q. And when they did away with  
11:12:14 16 the investigation of threshold cases did  
11:12:16 17 that have an impact on reducing the number  
11:12:18 18 of death investigations you personally did  
11:12:20 19 in long-term care homes?

11:12:22 20 A. Yes.

11:12:22 21 Q. And do you have any view  
11:12:29 22 about that, from your perspective, the value  
11:12:30 23 of threshold death investigations when you  
11:12:32 24 were doing them before 2013?

11:12:34 25 A. My thought is that it was --  
11:12:35 26 we're frequenting the nursing homes, the  
11:12:39 27 long-term care facilities a lot less than we  
11:12:42 28 were then. And we were in there on a  
11:12:44 29 regular basis and getting to know people and  
11:12:47 30 getting to know the situation I think a lot  
11:12:49 31 better.

11:12:50 32 Q. When you were doing the

1 threshold deaths?

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

10 Q. An educational thing for  
11 whom?

12 A. To maintain your competency  
13 as a coroner.

14 Q. For the coroners themselves?

15 A. Yes.

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

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

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

32

1 BY MS. JONES:

2 Q. Dr. George, you were giving  
3 evidence about your view on the value of the  
4 threshold death investigation. So putting  
5 aside all the standard steps you would take  
6 on an investigation, which I'll take you  
7 through a little bit more carefully in a  
8 moment, on a threshold death investigation  
9 was there anything unique about the  
10 investigations you did when it was threshold  
11 death investigation?

12 A. Well, you would be reviewing  
13 the death register that's maintained by the  
14 nursing home, and that provided lots of  
15 useful information that would, you know --  
16 glancing at that and reviewing that you  
17 could see how many deaths there were in a  
18 certain period of time; what kind of causes  
19 were entered on the death certificate and  
20 that kind of thing.

21 Q. I'm going to actually now  
22 pass you so that we can talk about the death  
23 register at this stage, Dr. George, this is  
24 document 71970 underscore 01 and I'm going  
25 to pass that up.

26 MS. JONES: Now, for the sake of  
27 the record this document has  
28 already been marked as an exhibit  
29 as document 71970, earlier in the  
30 proceeding or -- I believe it was  
31 part of the Facilities Overview  
32 Report, Commissioner. We've

11:15:36 1 conducted different redactions on  
11:15:39 2 this version so that we can have a  
11:15:41 3 little bit more information to  
11:15:43 4 assist Dr. George.  
11:15:44 5 So we'll look at this version and  
11:15:49 6 mark it at least for identification  
11:15:52 7 at this stage as well.

11:15:54 8 THE COMMISSIONER: Unless there's  
11:15:54 9 a problem it should probably be  
11:15:56 10 marked as an exhibit proper  
11:15:59 11 because it is different than the  
11:16:01 12 prior one, it has less redactions  
11:16:03 13 as I understand it.

11:16:04 14 BY MS. JONES:

11:16:04 15 Q. Let me ask you, Dr. George,  
11:16:07 16 do you have the document in front of you  
11:16:08 17 now?

11:16:09 18 A. Yes I do, thanks.

11:16:11 19 Q. And we see that your name  
11:16:12 20 appears three times on the right-hand side,  
11:16:15 21 correct?

11:16:16 22 A. Yes.

11:16:17 23 Q. So can we take it from the  
11:16:19 24 appearance of your name on this document  
11:16:22 25 that on the occasions that you attended at  
11:16:25 26 this home you would have reviewed the death  
11:16:28 27 registry?

11:16:29 28 A. Yes.

11:16:29 29 MS. JONES: So perhaps on that  
11:16:30 30 basis, Commissioner, we can mark  
11:16:32 31 this as the next exhibit?

11:16:34 32 THE COMMISSIONER: Thank you very



11:16:35 1 much. Madam Clerk, exhibit  
11:16:36 2 number?  
11:16:39 3 THE CLERK: 107.  
11:16:40 4 THE COMMISSIONER: 107, thank you  
11:16:40 5 very much. Just to be clear then,  
11:16:43 6 Exhibit 107 it has been already  
11:16:45 7 entered into evidence as document  
11:16:57 8 71 -- Ms. Jones?  
11:16:59 9 MS. JONES: Document number 71970.  
11:17:11 10 THE COMMISSIONER: Is it being  
11:17:11 11 entered as an exhibit because this  
11:17:13 12 document is not identical to  
11:17:15 13 document 71970.  
11:17:19 14 MS. JONES: Different redactions  
11:17:20 15 have applied to this version. The  
11:17:22 16 one that was entered earlier in  
11:17:23 17 the proceeding for some reason it  
11:17:25 18 was entirely blacked out, other  
11:17:27 19 than Mr. Silcox's name, so you  
11:17:29 20 couldn't see the causes of death  
11:17:32 21 or the dates of death or any of  
11:17:34 22 that information.  
11:17:35 23 THE COMMISSIONER: Thank you,  
11:17:35 24 counsel.  
10:11:42 25 EXHIBIT NO. 107: Document titled  
10:11:42 26 "Resident Death or Transfer Record  
10:11:42 27 for", document number 71970-01.  
11:17:36 28 BY MS. JONES:  
11:17:36 29 Q. Now, Dr. George, looking at  
11:17:39 30 this document and lets take, based on the  
11:17:43 31 Commissioner's question to you, the context  
11:17:44 32 of a threshold death investigation in

1 particular.

2 Can you walk us through what you  
3 would have done with the death register in  
4 that context?

5 A. If it was a threshold case I  
6 would be making sure that it was the tenth  
7 death that we were actually investigating.

8 Q. And how did you make sure of  
9 that?

10 A. They usually marked it.

11 Q. So they would mark somewhere  
12 on this form that this is the tenth death?

13 A. Yeah, the previous one would  
14 have been marked and then it would have been  
15 the next one would have been the tenth  
16 death.

17 Q. So you would determine that  
18 it was in fact the tenth death?

19 A. Whether it was a threshold  
20 case or not to start with.

21 Q. And then what would you do  
22 next?

23 A. And then I would investigate  
24 that case. I would review the chart, I  
25 would discuss the case with the nursing  
26 staff.

27 Q. This is the threshold death  
28 case itself?

29 A. That's right.

30 Q. And would that investigation  
31 differ from the investigations -- all the  
32 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.

1 Q. Did you ever when you were  
2 reviewing the death register find an example  
3 of a case that should have been reported and  
4 wasn't?

5 A. Not the death register.

6 Q. So not when reviewing the  
7 death register?

8 A. Not when reviewing the death  
9 register.

10 Q. And did you ever find  
11 examples when reviewing the death register  
12 of the death register itself not being  
13 properly completed? And I'm going to give  
14 you an example here.

15 A. At the top, I don't ever  
16 remember seeing those numbers filled in.

17 Q. Okay. So the numbers that  
18 you're referring to are the average number  
19 of deaths per month?

20 A. The ranges, yes.

21 Q. You never saw those filled  
22 in?

23 A. No.

24 Q. Did you ever ask for those to  
25 be filled in?

26 A. I believe perhaps once or  
27 twice I commented on that and nothing was  
28 ever done about it.

29 Q. Okay. And so in terms of --  
30 were you attempting to assess, when you're  
31 looking at the death register, whether the  
32 average number of deaths per month in the

11:21:46 1 facility or the average number of transfers  
11:21:49 2 per month in the facility had increased?

11:21:52 3 A. I would be looking for things  
11:21:54 4 like that. And, for example, looking at  
11:21:55 5 this one this covers -- Mr. Silcox passed  
11:21:58 6 away in August of 2007 and this register at  
11:22:01 7 the top of the page is from May 2007.

11:22:05 8 Q. Okay. So what does that tell  
11:22:07 9 you?

11:22:08 10 A. I didn't think that there  
11:22:11 11 were an unusually high number of deaths for  
11:22:13 12 that period.

11:22:14 13 Q. So you would do it by looking  
11:22:16 14 sort of up the page and getting a sense of  
11:22:19 15 whether there --

11:22:20 16 A. That's right.

11:22:21 17 Q. What would you be comparing  
11:22:22 18 it to though if you didn't have the  
11:22:24 19 information at the top completed?

11:22:26 20 A. I would also be looking at  
11:22:27 21 the cause of death on here too because that  
11:22:31 22 will also influence the number of deaths  
11:22:34 23 that are occurring. Because there was  
11:22:38 24 somebody with metastatic disease here, there  
11:22:41 25 was somebody with cirrhosis, that type of  
11:22:44 26 thing.

11:22:45 27 Q. But in terms of getting a  
11:22:46 28 sense of whether there had been an increased  
11:22:48 29 number of deaths or transfers what were you  
11:22:51 30 using to determine when you're looking at  
11:22:53 31 this that this is within the range that you  
11:22:56 32 expected or higher or lower? What were you

1 comparing it to the numbers of death?

2 A. I would simply be look at,  
3 you know, these numbers and making sure that  
4 perhaps there wasn't an excessive number in  
5 one month, for example, that type of thing,  
6 or in a shorter type frame.

7 Q. And then you just testified  
8 you would also look at the causes of death  
9 to see patterns in that regard?

10 A. Right. And as you can see  
11 from the register that a number of these  
12 patients were transferred to the hospital  
13 and that's where they died.

14 MS. JONES: Commissioner, I'm now  
15 going to ask Dr. George to walk  
16 through the steps of his death  
17 investigation in a long-term care  
18 home so perhaps it would be a good  
19 time for the morning recess.

20 THE COMMISSIONER: Yes, thank you  
21 very much, counsel.

22 -- RECESSED AT 11:23 A.M.

23 -- RESUMED AT 11:46 A.M.

24 THE COMMISSIONER: Go ahead,  
25 Ms. Jones.

26 BY MS. JONES:

27 Q. Dr. George, if we can now  
28 review your practice when conducting death  
29 investigations in long-term care homes. And  
30 my first question for you is is after you've  
31 determined that you are going to conduct a  
32 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



1 consists of?

2 A. How the patient is positioned  
3 in the bed or if they're on the floor, how  
4 they're clothed, their general nutritional  
5 status, the lividity, rigor, whether the  
6 body is cold to touch or not, that type of  
7 thing.

8 If the person had a surgical  
9 procedure, I'd be looking at the surgical  
10 site to make sure it was intact and that  
11 type of thing. Make sure that there are no  
12 marks of external violence on the body.  
13 Look around the room, make sure that there  
14 isn't anything, you know, of concern.

15 Q. Okay. And you mentioned  
16 lividity and rigor. What are those?

17 A. So rigor is, in layman's  
18 term, a general state of stiffness. So if  
19 it's within, you know, 4 hours of death,  
20 there usually isn't any rigor. It usually  
21 takes about 12 hours for rigor to set in.

22 And with respect to lividity,  
23 that's -- we talk about capillary refill and  
24 that type of thing. So in somebody who's  
25 just passed away and if you pressed on the  
26 skin, the capillaries would refill. If it  
27 was longer than that, then it would be  
28 fixed.

29 Q. And as the coroner in this  
30 situation, do you take blood samples or  
31 urine samples from the body?

32 A. No.

1 Q. And after you conduct this  
2 examination, what do you do next?

3 A. I would go back to the  
4 nursing station to review the chart and the  
5 death register and the other documentation  
6 that they would have ready.

7 Q. Okay. And in terms of the  
8 documentation you would review in the chart,  
9 what documentation would you look at?

10 A. I would be looking at the  
11 Progress Notes for, you know, the last  
12 period of the illness, if that's in  
13 question. I would be looking at the  
14 medication profile. I would be looking at,  
15 you know, when the patient was admitted to  
16 the long-term care facility, reading some of  
17 the nursing notes to find out if there are  
18 any concerns. If family is present, I would  
19 have a discussion with the family and see if  
20 they had any concerns or...

21 Q. Okay. So we'll get to the  
22 family discussion in a moment, but in terms  
23 of the medical records, you've mentioned the  
24 Progress Notes for the last period of the  
25 illness, the medication profile, information  
26 from when the patient was admitted. Is  
27 there anything else?

28 A. To find out what their  
29 general level of functioning was before this  
30 happened. If there were consultation  
31 reports on the chart, I would usually review  
32 those because they're usually a good

11:50:46 1 summary.

11:50:46 2 Q. Okay. Would you look at  
11:50:46 3 the -- what some people refer to as the face  
11:50:51 4 sheet at the front of the chart with the  
11:50:53 5 contact information?

11:50:53 6 A. Right. That's the  
11:50:55 7 demographic sheet.

11:50:54 8 Q. That's the demographic sheet.  
11:50:56 9 Okay.

11:50:56 10 And you've testified that you do  
11:51:02 11 this review of the medical records after you  
11:51:05 12 examine the body. Is there a particular  
11:51:08 13 reason for that order?

11:51:11 14 A. I think that my usual  
11:51:14 15 practice of doing that is so that if, you  
11:51:16 16 know, the body needs to be removed and that  
11:51:18 17 kind of stuff, then they can, you know,  
11:51:20 18 proceed with that.

11:51:22 19 Q. Is it ever the case, though,  
11:51:23 20 that you review something in the medical  
11:51:26 21 records which you didn't know when you were  
11:51:28 22 examining the body and wish to return to  
11:51:31 23 examine the body?

11:51:32 24 A. I may go back and look at the  
11:51:34 25 body. There's nothing that says that you  
11:51:35 26 can't.

11:51:36 27 Q. And then you referred to if  
11:51:39 28 the family is present, speaking to the  
11:51:41 29 family?

11:51:42 30 A. Or representative or power of  
11:51:43 31 attorney, you know, to find out additional  
11:51:47 32 information or find out if they have any

11:51:49 1 concerns.

11:51:49 2 Q. Okay. So do you have  
11:51:50 3 particular questions you ask of family  
11:51:52 4 members?

11:51:53 5 A. I usually start by expressing  
11:51:54 6 my condolences and meeting under those kind  
11:51:58 7 of circumstances, and then I try and find  
11:52:01 8 out a little bit of medical information from  
11:52:04 9 them and find out if they had any kind of  
11:52:07 10 concerns or if there were any problems going  
11:52:09 11 on and that type of thing.

11:52:10 12 Q. And why is that important, to  
11:52:12 13 find out if there's concerns or problems?

11:52:14 14 A. I think you can glean a lot  
11:52:16 15 of information from the family. They often  
11:52:19 16 provide a lot of very useful information  
11:52:22 17 that sometimes we miss in our medical  
11:52:24 18 documentation and that kind of stuff.

11:52:26 19 Q. And so you referred to if the  
11:52:27 20 family is present. What if the family is  
11:52:30 21 not present?

11:52:31 22 A. I would try and call. You  
11:52:33 23 know, on the face sheet or the demographic  
11:52:36 24 sheet, there's usually listed, you know, a  
11:52:39 25 contact person, and I would make an attempt  
11:52:40 26 to contact them.

11:52:41 27 Q. Okay. And when you say "make  
11:52:44 28 an attempt," if you didn't reach someone,  
11:52:47 29 what was your practice then?

11:52:48 30 A. I would try and call the  
11:52:49 31 second number or second person on the list.

11:52:51 32 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 1 Q. I did. So fair enough.

11:54:08 2 A. Yes.

11:54:08 3 Q. So providing the name, in  
11:54:09 4 your view, would not be appropriate?

11:54:12 5 A. Right, but I will -- it has  
11:54:14 6 been my practice to more recently in the  
11:54:18 7 last six or seven years to be writing I  
11:54:21 8 spoke with, you know, the spouse or the  
11:54:24 9 sister or the power of attorney regarding  
11:54:26 10 so-and-so, and postmortem examination was  
11:54:30 11 discussed, cause of death was discussed, or  
11:54:32 12 we had several discussions and that kind of  
11:54:34 13 thing.

11:54:34 14 Q. Okay. And why did you move  
11:54:36 15 towards that practice six or seven years  
11:54:39 16 ago?

11:54:40 17 A. I thought it was just better  
11:54:41 18 than saying that, you know, there were no  
11:54:43 19 concerns raised or that kind of thing. I --  
11:54:47 20 because as time went on, we -- I improved on  
11:54:59 21 the way that I write my narratives.

11:55:01 22 And we had a session with Dr. Mann  
11:55:03 23 that was very helpful on how to write a more  
11:55:06 24 appropriate narrative, a more informative  
11:55:10 25 narrative.

11:55:11 26 Q. Thank you. And then when you  
11:55:13 27 speak to the family, we heard earlier from  
11:55:17 28 Dr. Mann that there's a pamphlet that the  
11:55:20 29 regional office has.

11:55:21 30 If the family is present in the  
11:55:23 31 hospital, do you provide the family with the  
11:55:26 32 pamphlet or any other information?

11:55:27 1 A. I usually provide them with  
11:55:29 2 my card with my telephone number on it.

11:55:31 3 Q. Okay. And if you speak to  
11:55:34 4 someone over the telephone, do you provide  
11:55:36 5 them with any information, contact  
11:55:38 6 information, for you?

11:55:39 7 A. Yes.

11:55:40 8 Q. And do you ever, then,  
11:55:42 9 receive calls from family members?

11:55:44 10 A. Quite often.

11:55:46 11 Q. Okay. And when you receive a  
11:55:48 12 call from a family member later on, do you  
11:55:52 13 maintain notes of those calls?

11:55:55 14 A. If I haven't written the Form  
11:55:57 15 3, I will write in the Form 3 that I have,  
11:56:01 16 you know, discussed, you know, the cause of  
11:56:04 17 death or the postmortem findings or the case  
11:56:08 18 with the family on several occasions rather  
11:56:10 19 than on just one occasion.

11:56:11 20 Q. And if you've already written  
11:56:13 21 the Form 3, then do you maintain notes of  
11:56:15 22 those discussions?

11:56:17 23 A. Not usually.

11:56:18 24 Q. So we've now reviewed you  
11:56:26 25 attend at the home. You do an examination  
11:56:29 26 of the body. You review medical records.  
11:56:34 27 You speak to a member of the family or  
11:56:35 28 attempt to speak to a member of the family.  
11:56:39 29 Do you speak to anyone else?

11:56:40 30 A. I would, again, speak to the  
11:56:41 31 nursing staff to see if there was any more  
11:56:46 32 information that they were able to provide.

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Q. What about physicians?

A. Or the attending physician.

Q. And do you have a particular practice as between nursing staff or physicians, or does it vary?

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.

Q. And do you as a sort of standard practice request incident reports, if there had been any incident reports relating to the patient?

A. If there was a fall or something or if there was something unexplained, I would ask about that.

Q. You would ask to see an Incident Report?

A. To see the nursing -- the nursing notes on that.

Q. To see the nursing notes. Okay.

A. Right.

Q. And what about incident reports that are submitted perhaps to the Ministry? Do you ask to see those?

A. No, I haven't -- I haven't seen those.

Q. Now, how often in a long-term care home context would you, as part of your death investigation, order an autopsy?



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A. Rarely.

Q. Why is that?

A. It's usually not indicated, and most of the time, the cause of death, you know, bearing in mind, you know, the circumstances, is you can reasonably ascertain.

Q. Okay. And can you recall ever asking for a postmortem examination or autopsy in the context of a death in a long-term care home?

A. I can't.

Q. Okay.

THE COMMISSIONER: You cannot?

THE WITNESS: I cannot. Sorry.

THE COMMISSIONER: Not at all.

BY MS. JONES:

Q. When you say that normally in the long-term care home context you can discern the cause of death, can you assist us with the standard or the test on which you determine a cause of death?

A. Well, looking at a patient's comorbid conditions, you can make a reasonable assumption as to the -- as to the cause of death.

Q. And how much certainty do you need to have as to your assumption about the cause of death?

A. A reasonable amount of certainty.

Q. What does that mean, a

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1 reasonable amount of certainty?  
2 A. I think it would be fairly  
3 obvious what the cause of death was in most  
4 cases.  
5 Q. Okay. And Dr. Huyer gave  
6 evidence about a balance of probabilities  
7 test. Is that a test you use?  
8 A. That would be -- that would  
9 be -- that would be the same thing.  
10 Q. Okay. And so what does the  
11 balance of probabilities test mean to you?  
12 A. That it is -- it would be  
13 very likely, you know, that would be the  
14 cause of death that I was considering.  
15 Q. Very likely?  
16 A. Very likely. If I can  
17 backtrack for a minute.  
18 Q. Yes.  
19 A. I may have ordered a  
20 postmortem examination on a patient that may  
21 have been transferred from a nursing home to  
22 a hospital and passed away in the hospital.  
23 Q. Okay. Are you thinking of an  
24 example in which that --  
25 A. I might have done that a few  
26 years ago --  
27 Q. Okay. Thank you.  
28 A. -- but not recently.  
29 Q. Thank you. While you're  
30 conducting your investigation -- and, again,  
31 let's ground this in a long-term care home  
32 context -- are you maintaining notes?

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A. Yes.

Q. And I'm going to ask you to turn now -- it's Document 72838. And it's Tab 6, Dr. George.

A. Tab 6. Okay.

Q. I apologize. The number, I'm being told, is 72832.

A. Mine doesn't have a number on it, but it's Tab 6.

Q. That's fine. What is this document we're looking at?

A. This is the Coroner Investigation Worksheet that I think was in the briefcase that we were all presented with back in 2004 when we took the course. And it may be something that Dr. Mann also used, but I've made a habit of using this over the years.

Q. Okay.

A. And if I didn't use this and I had my laptop, I would be directly entering things into Form 3 while I was sitting there.

Q. I see. So is it fair to say that when conducting an investigation -- and, again, let's ground this in a long-term care home context -- you're maintaining notes either on your Coroner Investigation Worksheet or on your Form 3?

A. That's right.

Q. And after you do your notes on your Coroner Investigation Worksheet, if

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

12:03:06 1 you know, is supine on a stretcher in the  
12:03:10 2 emergency department. There were no marks  
12:03:12 3 of external violence. There was evidence of  
12:03:16 4 therapeutic intervention. And underneath  
12:03:18 5 that, there are boxes for rigor and  
12:03:20 6 lividity.

12:03:21 7 Q. So if you insert any  
12:03:24 8 information into that section of the Form 3,  
12:03:26 9 does it show up on the printout so that the  
12:03:30 10 Form 3s that we look at today would look  
12:03:33 11 different than the Form 3s on the Coroners  
12:03:36 12 Investigation --

12:03:37 13 A. I don't think -- I think that  
12:03:39 14 that's there for our purposes, but I don't  
12:03:42 15 think -- that's why that needs to be  
12:03:45 16 included in the narrative.

12:03:46 17 Q. Oh, I see. And then you put  
12:03:47 18 that information into the narrative?

12:03:51 19 A. That's right.

12:03:51 20 MS. JONES: Commissioner, this  
12:03:52 21 document, the Coroners  
12:03:55 22 Investigation Worksheet has not  
12:03:55 23 yet been marked as an exhibit, so  
12:03:57 24 if we can please make it the next  
12:03:59 25 exhibit.

12:03:59 26 THE COMMISSIONER: Yes.

12:04:01 27 Thank you. So is that Exhibit 108  
12:04:10 28 then, Madam Clerk?

12:04:11 29 THE REGISTRAR: Yes, that's  
12:04:12 30 right.

12:04:13 31 THE COMMISSIONER: Thank you.

12:04:15 32 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

1 on your notes when giving your evidence  
2 about the investigation.

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

8 A. That's correct.

9 Q. And if we look just at the  
10 very beginning of your narrative, at the  
11 bottom of the page, it says you were  
12 notified of the case at 05:15. So that's  
13 5:15 in the morning; correct?

14 A. That's correct.

15 Q. And you were on the scene at  
16 6:45 a.m.?

17 A. That's correct.

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

23 A. Yes.

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

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

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



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A. An accidental death.

Q. So you determined, then, that it was a coroners case by virtue of the fact it was an accident, and you arrived on the scene at 6:45?

A. That's correct.

Q. And if we actually turn up the Institutional Patient Death Record, which is Tab 8. It's Document 65226, page 123.

And you've testified that you didn't have the Institutional Patient Death Record at the time that you would be making your assessment about whether or not a case was a coroners case. Would you have it as part of your death investigation in a long-term care home?

A. No, I wouldn't. I wouldn't have a copy of this.

Q. And could you have asked for a copy of this?

A. I'm not sure if they would have provided it, but I certainly could have had a look at it.

Q. Okay. But it just wasn't your practice?

A. No.

Q. Because in this case, it looks like Ms. Wettlaufer completed both accidental death and sudden and unexpected, but you -- would you have been aware of the fact that she completed those two boxes?

12:09:37 1 A. No.

12:09:37 2 Q. Okay. So we can now turn  
12:09:39 3 back to 65227 or Tab 9 and back down in the  
12:09:54 4 narrative. And can you assist us, looking  
12:10:00 5 at your narrative, with the physical  
12:10:04 6 examination that you conducted of Mr. Silcox  
12:10:06 7 and any findings from that physical  
12:10:08 8 examination?

12:10:12 9 A. It's fairly straightforward.  
12:10:14 10 The gentleman was supine in bed. There  
12:10:18 11 wasn't any evidence that he'd been harmed or  
12:10:20 12 there was external violence by -- I noted  
12:10:23 13 that he was last seen alive at 02:00 hours  
12:10:28 14 by a nursing staff on rounds and then was  
12:10:29 15 found with vital signs absent at 3:55 in the  
12:10:35 16 morning.

12:10:35 17 Q. And if you keep reading,  
12:10:38 18 I believe there are more physical findings,  
12:10:40 19 Dr. George.

12:10:41 20 A. Right. The lividity, there  
12:10:45 21 was blanching, and rigor was absent.

12:10:47 22 Q. And you testified that you  
12:10:48 23 would typically look at Progress Notes in  
12:10:52 24 considering in a death investigation. So  
12:10:54 25 I'm going to ask you to turn to Tab 12A, and  
12:11:01 26 it will be Document 4711, and if you can  
12:11:21 27 please go to page 6 of this document, at the  
12:11:33 28 bottom of the page, please.

12:11:35 29 And we see that this note type is  
12:11:40 30 described as an admission note. And you  
12:11:43 31 testified earlier that you would look at the  
12:11:45 32 information on admission.

1 So is this the information that  
2 you believe you would have looked at in  
3 doing this investigation?

4 A. Yes.

5 Q. Okay. And taking your time  
6 to review this admission note, can you tell  
7 us what, from this note, would have been  
8 significant to you in doing your death  
9 investigation?

10 A. This gentleman was a recent  
11 admission to the long-term care facility.  
12 He had a history of insulin-dependent  
13 diabetes. He was hypertensive. He had a  
14 history of thyroid disease. He had a  
15 history of Alzheimer's disease and a history  
16 of diverticulosis. He'd been previously in  
17 hospital for quite some time as he'd had a  
18 stroke, and it was affecting his right side.

19 And so this gentleman was  
20 obviously awaiting admission to a nursing  
21 home somewhere, and so he was admitted to  
22 this long-term care facility, and it sounds  
23 like he had, you know, quite a few problems  
24 with mobility making him prone to falls.

25 Q. Okay. And was there any  
26 significance to you of the fact that he was  
27 prone to falls?

28 A. Unfortunately, this is a very  
29 common occurrence in long-term care  
30 facilities.

31 Q. And towards the bottom, it  
32 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

12:14:27 1 that have been in long-term care facilities  
12:14:29 2 for years, and it would be very difficult to  
12:14:31 3 review everything, but the most recent notes  
12:14:35 4 for the preceding several weeks would be,  
12:14:37 5 you know, most adequate in most cases.

12:14:40 6 Q. And if we turn to page 3,  
12:14:43 7 then, of the Progress Notes, we see at  
12:14:56 8 17:00, there's a note referencing a fall.  
12:15:06 9 And you testified a moment ago that you  
12:15:08 10 would have looked at the Progress Notes  
12:15:09 11 about the event surrounding any incident.

12:15:09 12 And so is that the type of  
12:15:14 13 Progress Note that you would looked at?

12:15:16 14 A. That's right. And there  
12:15:17 15 was -- I think this gentleman probably had  
12:15:20 16 several falls, and it was kind of uncertain  
12:15:23 17 as to, you know, which fall caused the  
12:15:25 18 fracture.

12:15:27 19 Q. And now if you go to page 2  
12:15:28 20 of this document at 22:18. Would you have  
12:15:43 21 understood from --

12:15:44 22 A. I'm sorry, page 2 --

12:15:46 23 Q. At 22:18.

12:15:50 24 A. I don't have a -- oh, there  
12:15:53 25 it is. Okay. On the 4th of August?

12:15:57 26 Q. That's right. What would you  
12:15:58 27 have understood from this note?

12:16:01 28 A. That the patient had hip  
12:16:03 29 surgery, had a Moore prosthesis put in, and  
12:16:11 30 they said that the surgery went well. He  
12:16:13 31 was restless postoperatively, and they gave  
12:16:17 32 something to settle him.

1 Q. And now, from this point  
2 forward, would you have reviewed the rest of  
3 the Progress Notes up to the time of  
4 Mr. Silcox's passing?

5 A. Yes.

6 Q. And if you go now to the  
7 first page, page 1 of this document, can you  
8 tell us what, if anything, you believe you  
9 concluded in relation to Mr. Silcox's death  
10 from these notes immediately preceding his  
11 passing and his passing?

12 A. The patient had been  
13 transferred back to the long-term care  
14 facility. The patient had been transferred  
15 on one occasion back to the hospital to have  
16 sutures removed and then transferred back.  
17 And it doesn't sound like he was doing very  
18 well postoperatively.

19 Q. And there's a note on page 1  
20 at 21:37, BS at 16:30, 1.8.

21 A. That's correct.

22 Q. What does that mean?

23 A. Blood sugar was 1.8 at 4:30  
24 just before supper.

25 Q. And is 1.8 high or low?

26 A. Is low.

27 Q. It's low. Would you have  
28 taken anything from that note in this  
29 gentleman?

30 A. It's a solitary number  
31 that -- where his blood sugar was low. This  
32 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 1 A. That he was admitted to  
12:21:12 2 hospital with a right surgical neck fracture  
12:21:18 3 and that it needed to be fixed.

12:21:21 4 Q. Okay. What's a surgical neck  
12:21:24 5 fracture?

12:21:25 6 A. Well, it's a hip fracture.

12:21:26 7 Q. Okay.

12:21:26 8 A. And so these are really quite  
12:21:30 9 serious, and they're usually as a result of  
12:21:35 10 trauma, as a result of a fall.

12:21:36 11 Q. Okay. And actually, there's  
12:21:37 12 one more document we should mark in relation  
12:21:38 13 to Mr. Silcox based on your practice, and  
12:21:39 14 that's what we've referred to as the face  
12:21:42 15 sheet or the demographic sheet.

12:21:45 16 A. Right.

12:21:45 17 Q. If you can turn to Tab 12B,  
12:21:47 18 and that's Document 65226, please, page 3.  
12:21:56 19 And is this the document you were referring  
12:22:12 20 to?

12:22:12 21 A. Yes.

12:22:13 22 Q. Okay. And if you scroll down  
12:22:14 23 one more page, it looks like it continues  
12:22:19 24 with a --

12:22:20 25 A. They're cards. It's on two  
12:22:22 26 sides.

12:22:21 27 Q. It's on two sides. Okay.  
12:22:22 28 Fair enough. And would you have reviewed  
12:22:24 29 both sides?

12:22:25 30 A. Yes.

12:22:25 31 Q. Okay.

12:22:25 32 MS. JONES: So if we can mark,

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Commissioner, the demographic sheet, two pages, as the next exhibit.

THE COMMISSIONER: Yes.

Thank you. So Document 65226, the Caressant Care Resident Information Form for Mr. James Silcox, two-page document, and that would be Exhibit 110.

MS. JONES: Thank you. And that's pages 3 and 4 of that document only.

THE COMMISSIONER: Thank you.

EXHIBIT NO. 110: The Caressant Care Resident Information Form for Mr. James Silcox, two-page document, Document 65226, pages 3 and 4.

BY MS. JONES:

Q. Okay. So now, Dr. George, going back to your Form 3 at Tab 9, Document 65227, you've described now where you would have obtained the past medical history. We see that you obtained details of Mr. Silcox's medications; is that correct?

A. That's correct.

Q. And why is that important, or why do you do that?

A. It's very important because most of these patients are on polypharmacy,

12:23:42 1 and there can be lots of interactions, and  
12:23:45 2 many of these medications are really  
12:23:47 3 quite -- you know, can have some side  
12:23:51 4 effects and may have some implications.

12:23:57 5 Q. And then if you look the  
12:23:59 6 third line down under "narrative," it says:  
12:24:02 7 [AS READ]

12:24:02 8 "His death was discussed with his  
12:24:05 9 family; they had no concerns."

12:24:07 10 So I take it because you have no  
12:24:11 11 recollection of Mr. Silcox's death  
12:24:14 12 investigation, you're not in a position to  
12:24:16 13 assist us with recalling the family?

12:24:21 14 A. No.

12:24:21 15 Q. Okay. And we do anticipate  
12:24:26 16 that there will be evidence at the inquiry  
12:24:29 17 from Mr. Silcox's daughter, Diane Crawford,  
12:24:30 18 and we anticipate that her evidence will be  
12:24:37 19 that at no time, did she or her mother or  
12:24:41 20 any other members of her family have a  
12:24:44 21 discussion with you, with the coroner, about  
12:24:46 22 her father's death.

12:24:48 23 What do you say about that  
12:24:51 24 anticipated evidence? Can you help us with  
12:24:54 25 that?

12:24:54 26 A. I don't recall. It's my  
12:24:55 27 usual practice to speak with the family.

12:24:58 28 Q. Okay. And are there ever  
12:25:01 29 instances where you might ask a caregiver --  
12:25:04 30 instead of speaking to the family, ask a  
12:25:07 31 nurse or a doctor, "Does the family have any  
12:25:09 32 concerns?"

12:25:10 1 A. It might happen.

12:25:11 2 Q. Okay. Are there any concerns

12:25:17 3 about obtaining that sort of information,

12:25:18 4 family concern information, from one of the

12:25:20 5 caregivers?

12:25:22 6 A. Potentially there could be.

12:25:23 7 Q. Okay. And what kinds of

12:25:25 8 concerns should we have about that?

12:25:27 9 A. They may not give you the

12:25:28 10 accurate picture, or the family may have an

12:25:31 11 entirely different perspective on things.

12:25:33 12 Q. Now, would it be best

12:25:40 13 practice, in your view, to make sure you

12:25:41 14 speak to a family member themselves as

12:25:45 15 opposed to getting this information

12:25:47 16 secondhand?

12:25:48 17 A. Absolutely. Always make an

12:25:49 18 attempt to speak to the family.

12:25:51 19 Q. When identifying which family

12:25:53 20 member to contact, how do you -- how do you

12:25:55 21 do that?

12:25:56 22 A. Usually I choose the person

12:26:01 23 who's designated on the -- on the

12:26:04 24 demographic sheet.

12:26:05 25 Q. Okay. And if there are a few

12:26:08 26 people --

12:26:09 27 A. Usually start at the top, or

12:26:10 28 sometimes the nursing home will have a --

12:26:14 29 put an asterisk next to the one to contact.

12:26:17 30 Q. Thank you. And I anticipate

12:26:18 31 that Ms. Crawford's evidence will also be

12:26:22 32 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.

1 Q. Okay. We do know -- just  
2 assist us who don't do death investigations.  
3 We can see from the Progress Notes that  
4 there was a fall. And we can see that he  
5 had surgery. Mr. Silcox had surgery, and we  
6 can see that he passed away after that  
7 surgery.

8 Is there anything else to assist  
9 us with the fact that the cause of death  
10 itself was the surgery as opposed to any  
11 other reason?

12 A. I don't think so.

13 Q. Okay. So when you reach that  
14 cause of death as your conclusion, how do  
15 you do that?

16 A. I've reviewed his chart, and  
17 it's really quite obvious --

18 Q. Okay.

19 A. -- the situation.

20 Q. Okay. So you were satisfied,  
21 based on the test that you had provided  
22 earlier, that it was --

23 A. That's right.

24 Q. I believe you used the  
25 language "very likely"?

26 A. Very likely, yes.

27 Q. Okay. Thank you. Would you  
28 have considered a postmortem for Mr. Silcox?

29 A. No.

30 Q. Why not?

31 A. I don't think anything would  
32 have been gained by it.

1 Q. And if you turn now to Tab  
2 10, which is Document 65226. This is  
3 Mr. Silcox's Medical Certificate of Death?

4 A. That's correct.

5 Q. Okay. And did you complete  
6 this document?

7 A. That's my handwriting from  
8 the cause of death below.

9 Q. If we start at cause of death  
10 and we go downwards, we see your  
11 handwriting?

12 A. Onwards, that's all my  
13 handwriting.

14 Q. Okay. And so is it the  
15 practice for a local coroner to complete the  
16 Medical Certificate of Death where there is  
17 a death investigation?

18 A. Yes.

19 Q. And who completes it  
20 otherwise?

21 A. A family doctor. If it's not  
22 a coroners case, then it would be another  
23 physician.

24 Q. And then if we turn to  
25 Tab 11, which is Document 65226, and we're  
26 looking at the Resident Death Form. If you  
27 could assist us with whether your  
28 handwriting appears on this document.

29 A. My handwriting is at the top  
30 down as far as the serrated, the double line  
31 that goes across the page.

32 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,



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I'm familiar with it now.

Q. Right. Okay. But you have no independent recollection outside?

A. No, outside of that not.

Q. And do you have any notes relating to receiving this call?

A. No, I do not.

Q. But you've now had an opportunity to review some of the records?

A. Yes.

Q. And does that include the I/CAD or the Provincial Dispatch Record?

A. Yes.

Q. And does that include the emergency room record from when Ms. Pickering was seen in the emergency room?

A. 23rd of March, yes.

Q. Thank you. And does that include Ms. Pickering's Progress Notes in the period -- let's say the two-week period?

A. That were provided, yes.

Q. Yes. Okay. I'm going to ask that you refer now to Exhibit 97, which is the Affidavit of Noelle Kelly. And that is on the database as AFF18. I'm going to ask you to turn to page 2, Dr. George, of the document.

From my review of the records and Ms. Kelly's Affidavit, it appears that the first contact you had in relation to Ms. Pickering's death was at 8:37 on

1 March 28th, 2014.

2 Is that consistent with what  
3 you've been able --

4 A. Yes.

5 Q. -- to discern from your  
6 review?

7 A. Yes.

8 Q. Okay. And Ms. Kelly's  
9 Affidavit states that she contacted you,  
10 that she does not have a note of her  
11 discussion with you at this time, but that  
12 it's her general practice to provide the  
13 investigating coroner with all the  
14 information that she is provided regarding  
15 the circumstances of a death that have been  
16 reported to her.

17 And if you look up at B and C of  
18 Ms. Kelly's Affidavit, you see reference to  
19 Ms. Kelly having information at B from a  
20 nurse at Caressant Care, Karen Routledge,  
21 that Ms. Pickering had gone to the hospital,  
22 found to have low blood sugar. There's a  
23 question mark there.

24 "Dr. Urbantke, one of our coroners,  
25 advised the nursing home to call  
26 the case in once she dies. Not  
27 sure if there's more to it or not."

28 And at C, it appears that  
29 Ms. Kelly spoke to Dr. Urbantke. And  
30 Dr. Urbantke is who? Who's Dr. Urbantke?

31 A. Dr. Urbantke is another  
32 coroner, but she also works in our emergency

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1 department.  
2 Q. Okay. And is it your  
3 understanding she had been involved in  
4 Ms. Pickering's treatment at the hospital?  
5 A. Yes.  
6 Q. Okay. And so it appears that  
7 Ms. Kelly called Dr. Urbantke to assign her  
8 as the investigating coroner. And we see  
9 that Dr. Urbantke declined that on the basis  
10 that it would be a conflict because she was  
11 also a treating physician; correct?  
12 A. Correct.  
13 Q. Okay. And that the  
14 information is -- from Dr. Urbantke was that  
15 the blood sugar was less than 1 and was  
16 unexplained. She can't take the case  
17 because she saw her in the ER but will speak  
18 to the coroner to give more background  
19 information.  
20 Okay. So in relation to this  
21 information that Ms. Pickering was found to  
22 have low blood sugar and that Dr. Urbantke  
23 felt that a coroner should be called, do you  
24 have any reason to believe that you did not  
25 receive that information on March 28th?  
26 A. No.  
27 Q. Okay. So do you accept that  
28 you would have received that information?  
29 Okay.  
30 THE COURT REPORTER: Excuse me,  
31 I didn't get an answer.  
32 MS. JONES: Yes.

1 BY MS. JONES:

2 Q. If we then -- and actually,  
3 before we leave that document, at Tab D, it  
4 says -- I apologize. At paragraph 5D, it  
5 says:

6 "Dr. George accepted the case."  
7 And then Ms. Kelly has clarified:  
8 "I.e., agreed to look into the  
9 matter."

10 So what does "accepted the case"  
11 in this context mean?

12 A. She provided me with a  
13 synopsis of the situation and a contact  
14 telephone and told me what had gone on. And  
15 then I made phone calls and, you know,  
16 investigated into -- into her death.

17 Q. And does "accepted the case"  
18 in this context mean accepted it as a death  
19 investigation or accepted that you would do  
20 an assessment of whether or not --

21 A. Accepted you would do an  
22 assessment.

23 Q. Okay. So you accepted  
24 meaning you would now undertake a  
25 consideration of whether or not it met the  
26 criteria for a death investigation?

27 A. That's right.

28 Q. Okay.

29 A. If I can comment that it's --  
30 in a hospital two days ago, that's not  
31 accurate. It was five days prior to that.

32 Q. That's correct. Thank you.

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

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have been?

A. Absolutely.

Q. Okay. Now, if we look at the 09:50 note, do you have any reason -- or any evidence to provide about whether or not 09:50 was your first conversation with Ms. Routledge? Your only conversation with Ms. Routledge? Can you assist us with that?

A. What tab are we at again?

Q. At Tab 28, the first page, Dr. George.

THE COMMISSIONER: The 9:50 is in the middle of the 9:23 note.

THE WITNESS: Yes. Okay. Thanks. It would -- it would have been my usual practice to call almost immediately after I had hung up with dispatch.

BY MS. JONES:

Q. Okay. And so does that lead you to have a belief about whether or not this was the first time you spoke to Ms. Routledge?

A. It may not have been.

Q. It may not have been. You can't tell us either way?

A. It's my practice to call immediately after, and then it's likely that I was gathering more information from her visit from the hospital.

Q. Okay. And so what would 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



1 a long time in order to precipitate that.

2 Q. Okay. Your understanding was  
3 in order to precipitate hypoglycemic  
4 encephalopathy which would show up as a  
5 stroke, you would need a prolonged period of  
6 low blood sugar?

7 A. I'm not sure that it would  
8 show up as a stroke, but the encephalopathy  
9 would be -- there would be different changes  
10 on the CT scan. And she already had some  
11 changes on her CT as a result of her  
12 dementia.

13 Q. As a result of her dementia?

14 A. Yes.

15 Q. Okay.

16 THE COMMISSIONER: Okay. I  
17 don't think I understood fully  
18 your answers to all those  
19 questions.

20 THE WITNESS: Okay.

21 MS. JONES: We can break it down a  
22 little bit more, Commissioner.

23 THE COMMISSIONER: Thank you.

24 Start with the question of what he  
25 understood hypoglycemia could do  
26 to the brain.

27 BY MS. JONES:

28 Q. Okay. So were you familiar  
29 with the condition of hypoglycemic  
30 encephalopathy?

31 A. Yes.

32 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.

1 Q. Okay. And then going back to  
2 make sure we go through it little bit more  
3 slowly, I asked you -- your evidence was  
4 that you were satisfied based -- or you  
5 believe now you would have been satisfied  
6 that she had a stroke because there was  
7 imaging which suggested a stroke?

8 A. A new stroke.

9 Q. A new stroke. Okay.

10 And my question to you was in  
11 imaging, when looking at a CT scan, is it  
12 possible to mistake a stroke with  
13 hypoglycemic encephalopathy?

14 A. I'm not sure, but I doubt it.  
15 This -- it appeared to be a pontine infarct,  
16 which means that there was some sort of  
17 thrombotic event or some sort of a, you  
18 know, blood clot that would have caused  
19 that.

20 Q. Okay. So do you believe you  
21 would have been concerned that the stroke  
22 was, in fact, hypoglycemic encephalopathy,  
23 or that would not have been a concern?

24 A. No, it wasn't my concern.

25 Q. And would you have, in  
26 considering this case, attempted to come up  
27 with a reason for Ms. Pickering's extremely  
28 low blood sugar? Would that have been part  
29 of your consideration?

30 A. Yes.

31 Q. Okay. And what do you  
32 believe you would have considered when

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determining or considering why her blood sugar had been extremely low on that day?

A. I would be considering a medication error as well as her medications. And she was on numerous antipsychotics, which can accentuate hypoglycemia.

Q. But a medication error would have been one of your considerations for this blood sugar?

A. Would have been one of them, yes.

Q. If there's the possibility of a medication error in the patient's time -- immediately preceding the patient's death, is that not a reason for a coroners investigation?

A. If the medication precipitated the death, that would be reason for a coroners investigation.

Q. Okay. So from that answer, would you have reached a conclusion about whether or not, if there had been a medication error, it had resulted in the patient's death?

A. That's right.

Q. You would have considered that?

A. Yes.

Q. Okay. And based on your answer, what would your conclusion have been?

A. In this particular situation?

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Q. Yes.

A. That there was probably a medication error and that it was a solitary event.

Q. Okay. And what relationship would you have concluded there was between the medication error and Ms. Pickering's death?

A. I didn't think it was related to her death.

Q. Dr. George, looking back at these circumstances now and attempting to take out of your mind what we now know about Ms. Wettlaufer's offences, do you think you should have investigated this death?

A. No.

Q. Why not?

A. Because the death was foreseeable and expected.

Q. And that was based on, as you've testified, Ms. Pickering's palliative status and the fact that you understood she'd had a stroke?

A. That's correct.

MS. JONES: Thank you, Dr. George. I have no further questions. So, Commissioner, I will ask now counsel to the province if they have any questions in-chief.

THE COMMISSIONER: Thank you, Ms. Jones.

MS. BAMBERS: Can I just have a

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moment?

THE COMMISSIONER: Yes, you may.

MS. BAMBERS: Thank you,  
Commissioner.

EXAMINATION IN-CHIEF BY MS. BAMBERS:

Q. Just a couple questions,  
Dr. George. When you said that if the  
family contacted you to get more information  
about your decision, your conclusions on  
investigating the death of Mr. Silcox, that  
you would not have been dismissive. What is  
your practice if a family contacts you?

A. I'm more than happy to speak  
with them, and we've even had people come  
into the office and -- because they had more  
than one family member that wanted to  
discuss this, and that's been quite a common  
event.

Q. All right. And regarding the  
information -- you said that you had no  
information to contradict what Noelle Kelly  
indicated was her usual practice of  
providing information to coroners when she's  
contacting a coroner, but you don't have any  
recollection of exactly what she told you?

A. No. And I'm not sure that it  
would be verbatim what she documented in her  
record.

Q. All right. And you believe  
that you would have reviewed certain things  
from the time that you were called until  
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 1 hour and 15 minutes.  
12:52:22 2 -- RECESSED AT 12:52 P.M.  
12:52:22 3 -- RESUMED AT 2:13 P.M.  
12:52:22 4 CROSS-EXAMINATION BY MR. VAN KRALINGEN:  
12:52:22 5 Q. I've placed before you, and,  
02:13:37 6 Madam Commissioner, hopefully you'll have a  
02:13:40 7 copy, of a small group of documents that I  
02:13:42 8 plan to reference in today's examination.  
02:13:44 9 In the usual course I tend to go  
02:13:47 10 sequentially but given some of your answers  
02:13:49 11 we might bounce around in the document just a  
02:13:51 12 little bit, just so you know.  
02:13:52 13 A. Okay.  
02:13:54 14 Q. Ms. Jones asked a little bit  
02:13:55 15 about your background and your practice.  
02:13:57 16 What I was unclear about after her  
02:14:00 17 conversation with you is what percentage of  
02:14:01 18 your practice is doing coroner's work?  
02:14:08 19 A. Probably like 5 percent.  
02:14:10 20 Q. And has that percentage  
02:14:11 21 materially changed since 2007?  
02:14:13 22 A. Not really, no.  
02:14:14 23 Q. Has it ever changed during  
02:14:15 24 the course of your career?  
02:14:17 25 A. As I said before, sometimes  
02:14:18 26 it's busier than other times but it's a  
02:14:22 27 small portion of my practice.  
02:14:24 28 Q. As you discussed with  
02:14:24 29 Ms. Jones, you're aware from time-to-time  
02:14:26 30 the Office of the Chief Coroner or the  
02:14:29 31 Regional Senior Coroner will circulate  
02:14:31 32 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

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1 notes, is that right?  
2 A. That's correct.  
3 Q. I just don't understand why  
4 you would keep them for a few weeks and then  
5 discard them? What is the logic there?  
6 A. They would probably be on my  
7 desk and in the coroner's -- I have a file  
8 on my desk that, a plastic file where I file  
9 stuff. And so if it's not a coroners case I  
10 didn't see any reason to keep it further.  
11 Q. I understand that, but you're  
12 not saying that the choice to keep your  
13 notes for a few weeks is out of any reason  
14 connected to your role as a coroner?  
15 A. No.  
16 Q. It's just the way you  
17 administrate your notes?  
18 A. It's just the way I was  
19 administering.  
20 Q. Can I better understand the  
21 reason why you've chosen not to retain your  
22 notes relating to a death investigation that  
23 was declined?  
24 A. I didn't think it was  
25 necessarily, and when it was implemented I  
26 thought it was more for monetary reasons.  
27 Q. Can you explain that?  
28 A. Well, up until when that form  
29 came in we had another form and we weren't  
30 paid for taking calls, and there was no  
31 requirement at that time. And so we had a  
32 different type of a form that was submitted

02:17:42 1 for a while that we weren't reimbursed for.  
02:17:45 2 And this was voiced at some of the coroner  
02:17:48 3 conferences that some of the coroners in  
02:17:51 4 bigger cities that were receiving a lot of  
02:17:53 5 calls for noncoroner cases wanted to be  
02:17:57 6 reimbursed for them. And that's how that  
02:18:03 7 came about.

02:18:05 8 Q. Is it fair to say that your  
02:18:06 9 usual practice was not to inform the  
02:18:08 10 Regional Senior Coroners office when you  
02:18:11 11 chose to decline a death investigation?

02:18:13 12 A. That's correct. There would  
02:18:14 13 be occasion when I would call him and ask  
02:18:16 14 him about a certain case whether, you know,  
02:18:19 15 this would be appropriate as a coroners case  
02:18:22 16 or not?

02:18:23 17 Q. But those would be few and  
02:18:24 18 far between, is that fair to say?

02:18:26 19 A. They would, you know, every  
02:18:28 20 several months. We have missed cases that  
02:18:30 21 often come up because as my role as a  
02:18:33 22 coroner I also issue death -- issue  
02:18:37 23 cremation certificate. So a cremation  
02:18:40 24 certificate has to come across a coroner's  
02:18:43 25 desk. And so if there's something on the  
02:18:46 26 cremation certificate that raises concerns,  
02:18:48 27 such as an accidental fall, or a head  
02:18:51 28 injury, or that kind of stuff and it's  
02:18:54 29 already been signed off as a non-coroners  
02:18:55 30 death that becomes a missed case and someone  
02:19:00 31 would have to investigate that, usually just  
02:19:03 32 doing a chart review.

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Q. How frequent is that?

A. It happens with -- still happens with some frequency in the province.

Q. In the course of your work have you spoken with other local coroners about their practices regarding keeping notes or completing the death selection form when they decline a death investigation?

A. Yes.

Q. Can you tell me about those conversations?

A. At the recent coroners conference last November there were numerous other coroners that didn't submit the form either.

Q. But did they tell you why they weren't submitting it?

A. They didn't think it was necessary.

Q. And that's not just for the London region that's from coroners across the Province?

A. That's from coroners across the Province, yes.

Q. And the reason they weren't submitting those forms is that they didn't see them to be of any value?

A. That's correct.

Q. I assume that you understand that the Regional Senior Coroners office has various oversight responsibilities in connection with its local coroners?

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A. That's correct.

Q. One of those oversight responsibilities is with respect to evaluating the work of local coroners, including the decision not to conduct a death investigation, is that your understanding?

A. That's correct.

Q. To your mind if a local coroner chooses not to file a Case Selection Data Form, or keep any notes of their decision not to accept a death investigation, does that hinder the ability of the Regional Senior Coroner to provide input on to whether that refusal was a reasonable decision?

A. I don't think so.

Q. How would they learn about the fact that the decision occurred?

A. Well, from the numbers that I saw earlier it didn't appear that a lot of those forms were being submitted.

Q. That's not the question. I think you're answering a different question.

A. Sorry.

Q. It's all right. I'll restate my question?

A. Can you rephrase it?

Q. No, no, for sure I will. If you don't hand in a Case Selection Data Form and you don't keep any notes the Regional Senior Coroner doesn't

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know that you've declined a death investigation, is that fair?

A. That's correct.

Q. So how could they possibly have any oversight of your decision to decline a death investigation?

A. They would know from the number of cases that were seen -- that were called in to central dispatch.

Q. And your belief is that the Regional Senior Coroner reviews the cases that are sent to central dispatch?

A. They know the number of cases that we each accept and decline.

Q. Can you go to tab 1 of the documents that I've given you in the yellow binder? This is the document 71383. This document is called "Chapter 5 Apparently Natural Deaths" and it's taken from the Coroners Investigation Manual. Are you familiar with this document?

A. Yes.

Q. In your personal practice my understanding is that you access your coroners Manual electronically?

A. That's correct.

Q. Do you keep it with you when you go to conduct death investigations?

A. Yes.

Q. And do you have it with you when you make decisions as to whether to conduct a death investigation or not?

02:22:07 1 A. I almost always have my  
02:22:09 2 laptop with me.

02:22:13 3 Q. Third paragraph here says:  
02:22:13 4 "When an apparently natural death  
02:22:17 5 is reported to the coroner, the  
02:22:20 6 first responsibility is to assess  
02:22:22 7 as fully as possible whether this  
02:22:25 8 death requires a coroner  
02:22:26 9 investigation. This will require  
02:22:28 10 the coroner to obtain adequate  
02:22:30 11 information from the reporting  
02:22:32 12 person involved in the case."

02:22:34 13 Do you agree that this is an  
02:22:36 14 appropriate explanation of your obligation?  
02:22:38 15 To obtain information relating to -- adequate  
02:22:45 16 information from the reporting person?

02:22:47 17 A. Yes.

02:22:49 18 Q. And below section A it says  
02:22:51 19 that the coroner should obtain as much  
02:22:53 20 information as possible to make an informed  
02:22:56 21 decision. I suppose my question is this,  
02:23:00 22 because I don't have any notes, your  
02:23:03 23 contemporaneous notes from your decision  
02:23:06 24 with respect to Ms. Pickering, and I don't  
02:23:07 25 actually have a sense of what your process  
02:23:10 26 is, despite your discussion with Ms. Jones,  
02:23:12 27 I'd like to know how long does your process  
02:23:14 28 typically take to determine whether a death  
02:23:17 29 investigation is appropriate in any given  
02:23:19 30 circumstance?

02:23:19 31 A. It would vary on the  
02:23:21 32 information that I'm provided.



02:23:24 1 Q. Does the length of your  
02:23:25 2 process typically change when you're dealing  
02:23:27 3 with a death in a long-term care home?

02:23:31 4 A. No, it's about the same.

02:23:33 5 Q. How often are you called with  
02:23:34 6 respect to a death in a long-term care home?

02:23:37 7 A. Not very often. I can't  
02:23:39 8 recall the last time I've been to a  
02:23:40 9 long-term care facility.

02:23:43 10 Q. In fact my understanding is  
02:23:44 11 that it has been approximately four to five  
02:23:47 12 years since you've conducted any death  
02:23:48 13 investigation in a long-term care home, is  
02:23:50 14 that fair to say?

02:23:51 15 A. I think so.

02:23:54 16 Q. Why is that?

02:23:56 17 A. At one time we were being  
02:23:58 18 called for threshold cases and that stopped  
02:24:01 19 in 2013. And, as I said, recently sometimes  
02:24:06 20 when patients are transferred to the  
02:24:08 21 hospital that would be a coroners  
02:24:11 22 investigation where the primary site would  
02:24:13 23 have -- primary injury site would have been  
02:24:16 24 in the nursing home.

02:24:18 25 But I haven't been to the nursing  
02:24:20 26 home for a coroners case in a number of  
02:24:22 27 years.

02:24:27 28 Q. My understanding, from your  
02:24:29 29 conversation with Ms. Jones, is that your  
02:24:32 30 position is that deaths at a long-term care  
02:24:33 31 home can truly never be unexpected, is that  
02:24:37 32 fair to say?

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A. I would never say never but highly unlikely.

Q. Highly unlikely. And do you think it's a useful criterion to have on the Institutional Patient Death Record given what you've just suggested?

A. I don't think it's useful.

Q. Nevertheless it is a criteria on the Institution Patient Death Record, you would agree?

A. Yes.

Q. Can you go to page 3 of the same document please? In the middle of the page, and if you could -- that's perfect. Thank you.

It says:  
"The investigation should be conducted with an open mind considering all manners of death as an initial possibility and, ruling manners of death out based on the evidence collected."  
You'll agree with me that that direction would include nefarious actors?

A. That's right.

Q. Can you go to tab 2 of the documents you have?

A. It's document 71449.

Q. This is a circular or memorandum circulated on September 20th, 2010, from the then Chief Coroner of Ontario 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 1 Q. Go to tab 3 of the documents  
02:27:35 2 you have.

02:27:36 3 Madam Commissioner, tab 3 of your  
02:27:39 4 document is a different copy of the one  
02:27:40 5 that's in evidence so I'm going to ask that  
02:27:42 6 the one in evidence be pulled up, it's 71435.

02:27:52 7 THE COMMISSIONER: Thank you.

02:27:52 8 BY MR. VAN KRALINGEN:

02:27:52 9 Q. This is the best practice  
02:27:54 10 guidelines of "Investigating Coroners  
02:27:56 11 Acceptance of Natural Deaths for  
02:27:59 12 Investigation". I assume that you've  
02:28:00 13 reviewed this before?

02:28:02 14 A. Yes.

02:28:02 15 Q. And I assume that you use  
02:28:04 16 this in the course of your coroner's  
02:28:06 17 practice?

02:28:07 18 A. Yes.

02:28:07 19 Q. Can we go to page 2 please?  
02:28:09 20 Page 2 is a decision tool, and I assume that  
02:28:13 21 this decision tool is something that you  
02:28:16 22 would regularly use in your practice?

02:28:18 23 A. Regularly.

02:28:20 24 Q. If a nondiabetic patient had  
02:28:22 25 unexplained, severe hypoglycemia before  
02:28:26 26 their death to your mind would that affect  
02:28:27 27 the answers to any of the questions in this  
02:28:29 28 decision tool?

02:28:30 29 A. No.

02:28:31 30 Q. Similarly, if a doctor  
02:28:32 31 specifically raised a concern relating to  
02:28:34 32 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

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1 you've looked at, and I'm going to speak  
2 about that later, is essentially you  
3 refreshing your recollections in advance of  
4 this Inquiry by looking at the medical  
5 documents?  
6 A. That's correct.  
7 Q. Go to page 4 of this document  
8 please. Page 4 of this document excerpts  
9 certain portions of the Coroners Act. Under  
10 the section that says, "Decision to Accept a  
11 Natural Death for Investigation", if you can  
12 bring it up a little bit? Perfect.  
13 It says:  
14 "Common scenarios where a natural  
15 death may not necessarily be  
16 accepted for investigation would  
17 fall under section 10.1(d) suddenly  
18 and unexpectedly, or section  
19 10.1(g) under such circumstances as  
20 may require investigation."  
21 To your mind if a treating doctor  
22 says it might be a good idea to call the  
23 coroner on this one would that constitute  
24 such circumstances as may require  
25 investigation?  
26 A. It may, yes.  
27 Q. It may?  
28 A. Yes.  
29 Q. Can you go to the next tab  
30 please? Tab 4.  
31 Tab 4 is again, Commissioner, I'm  
32 going to give the right number, 71436, which

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1 is the Case Selection Data Form.  
2 THE COMMISSIONER: Thank you.  
3 BY MR. VAN KRALINGEN:  
4 Q. I want to take you back sort  
5 of in advance of Ms. Wettlaufer's crimes  
6 coming to light. At that time did you feel  
7 that this was a particularly onerous form to  
8 complete?  
9 A. It's not onerous, no.  
10 Q. So it's not a question of it  
11 being hard or time consuming to complete it  
12 you just saw no value in the form being  
13 completed, is that fair to say?  
14 A. Well, I used the decision  
15 criteria on the form each time I was  
16 speaking to somebody on the phone.  
17 Q. I'll be more precise with my  
18 question.  
19 Then you saw no value in completing  
20 the form but you had a use for the form?  
21 A. Yes, I had a use for the  
22 form.  
23 Q. But you saw no value in  
24 completing it?  
25 A. I didn't complete it.  
26 Q. Can we go to next document  
27 please? Tab 5. It's document 69309.  
28 This is the section of the Coroners  
29 Investigation Manual, chapter 11, dealing  
30 with institutional deaths. Again I assume  
31 you're familiar with this chapter?  
32 A. Yes.

02:32:36 1 Q. In your conversation with  
02:32:37 2 Ms. Jones earlier today you indicated that  
02:32:38 3 it didn't occur to you that a healthcare  
02:32:42 4 provider would be intentionally harming  
02:32:44 5 their patients when you were conducting  
02:32:45 6 death investigations, is that fair to say?

02:32:48 7 A. Not in this situation.

02:32:49 8 Q. In any situation?

02:32:50 9 A. Well, I can't think of a case  
02:32:51 10 in a long-term care facility that I've been  
02:32:53 11 involved in.

02:32:54 12 Q. And again just to be precise  
02:32:56 13 with my question, I'm not just speaking  
02:32:58 14 about death investigations I'm also posing  
02:33:00 15 my question with respect to the decision to  
02:33:02 16 conduct a death investigation. I assume  
02:33:04 17 your answers are the same?

02:33:06 18 A. Yes.

02:33:07 19 Q. Can we go to the third  
02:33:08 20 paragraph here:

02:33:09 21 "From an investigative perspective  
02:33:12 22 the elderly living in a long-term  
02:33:14 23 care home should be thought of as a  
02:33:18 24 vulnerable population. While the  
02:33:20 25 vast majority of their deaths are  
02:33:22 26 uncomplicated the coroner needs to  
02:33:24 27 be open to the possibility of  
02:33:26 28 injury, abuse and neglect in the  
02:33:28 29 same way as one would when  
02:33:30 30 investigating the death of a child  
02:33:31 31 or other vulnerable member of our  
02:33:33 32 society."



02:33:33 1 So I assume you'll agree with me,  
02:33:35 2 based on what I've read, that the Manual  
02:33:37 3 expressly calls long-term care residents  
02:33:40 4 "vulnerable"?

02:33:41 5 A. Yes.

02:33:42 6 Q. The Corners Manual here  
02:33:44 7 expressly asks local corners to contemplate  
02:33:47 8 the possibility of abuse, you would agree  
02:33:49 9 with that?

02:33:50 10 A. Yes.

02:33:50 11 Q. And it doesn't differentiate  
02:33:53 12 between abuse of healthcare providers and  
02:33:56 13 abuse of anybody else, would you agree with  
02:33:58 14 that.

02:33:59 15 A. Agreed.

02:34:01 16 Q. So I assume as part of your  
02:34:02 17 training you were asked to review this  
02:34:04 18 manual, is that fair to say?

02:34:06 19 A. That's correct, it was an  
02:34:07 20 earlier version.

02:34:08 21 Q. Did you ever have any  
02:34:09 22 training specifically contemplating the  
02:34:12 23 possibility of resident abuse and that being  
02:34:14 24 a reason for death?

02:34:17 25 A. Not specifically.

02:34:18 26 Q. Okay. I'm going to ask you  
02:34:21 27 to look at a document that you don't have in  
02:34:23 28 your package there and it's been entered in  
02:34:26 29 before.

02:34:26 30 Hopefully we can just deal with it  
02:34:28 31 on the screen, Madam Commissioner.

02:34:31 32 It's document 71434. This is a

02:34:38 1 PowerPoint presentation in 2013 put on by  
02:34:42 2 Dr. Skinner, who is the Deputy Chief Coroner  
02:34:43 3 for investigations. It is an educational  
02:34:47 4 session for other coroners. It's called  
02:34:49 5 "Death Investigations in Long-Term Homes, An  
02:34:53 6 Approach", and if you can kindly turn to page  
02:34:57 7 12 please?

02:34:57 8 A. Do I have this?

02:34:59 9 Q. It will be on the screen in  
02:35:01 10 front of you. The question is, "What's  
02:35:24 11 different about this population?" Answer 1,  
02:35:26 12 "Nothing". "Deserving of the same degree of  
02:35:28 13 death investigation as anyone else." Answer  
02:35:32 14 2:

02:35:32 15 "Everything. Vulnerable  
02:35:33 16 population, similar potential  
02:35:35 17 issues as in pediatric death  
02:35:38 18 investigations"

02:35:38 19 And the third one is important for  
02:35:39 20 my purposes for my question:

02:35:41 21 "Caregivers may conceal evidence of  
02:35:43 22 abuse/neglect by staff, family or  
02:35:47 23 other residents."

02:35:48 24 So my question to you is, in any of  
02:35:49 25 the continuing education you obtained was it  
02:35:52 26 ever discussed with you that those  
02:35:54 27 responsible for caring for residents in  
02:35:56 28 long-term care homes might try and conceal  
02:35:59 29 their evidence of abuse?

02:36:00 30 A. Not to any of the conferences  
02:36:02 31 that I've been.

02:36:04 32 Q. Has that come up in any other

02:36:05 1 educational format, in particular a circular  
02:36:09 2 that you may have received?

02:36:11 3 A. Yes, and at the last coroner's  
02:36:14 4 conference some of the abuse was discussed  
02:36:17 5 in long-term care facilities.

02:36:19 6 Q. The last coroners conference  
02:36:22 7 in November of last year?

02:36:23 8 A. November of 2017.

02:36:25 9 Q. Before then though, because I  
02:36:26 10 was obviously post-dating Ms. Wettlaufer's  
02:36:29 11 confession. Before then do you remember  
02:36:31 12 receiving any education on these issues?

02:36:34 13 A. No.

02:36:35 14 Q. Could you go to tab 6 of the  
02:36:36 15 documents you have in front of you? It's  
02:36:38 16 document 61287. Have you heard of the  
02:36:51 17 geriatric and long-term care review  
02:36:51 18 committee?

02:36:54 19 A. Yes.

02:36:55 20 Q. Broadly do you know what  
02:36:56 21 their function is?

02:36:56 22 A. They're to investigate deaths  
02:36:58 23 in long-term care facilities.

02:37:01 24 Q. And also to provide best  
02:37:02 25 practices on a going-forward basis for those  
02:37:05 26 who work in those facilities?

02:37:07 27 A. Yes.

02:37:08 28 Q. If you could go please to --  
02:37:10 29 just after the blue page in your excerpt,  
02:37:12 30 and for the benefit of everyone else it's  
02:37:14 31 page 10.

02:37:17 32 Do you ever read these reports when

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

02:38:48 1 a patient's condition may well indicate that  
02:38:51 2 something very serious is going on?

02:38:53 3 A. Absolutely.

02:38:54 4 Q. And so those values would  
02:38:56 5 inform your decision to either choose to  
02:38:58 6 conduct or not choose to conduct a death  
02:39:00 7 investigation?

02:39:01 8 A. That's correct.

02:39:03 9 Q. Can you go to the next tab  
02:39:09 10 please? Tab 7, document 69322. This is a  
02:39:19 11 best practice guideline with respect to  
02:39:23 12 providing guidance with respect to  
02:39:24 13 investigating coroners ordering post-mortem  
02:39:29 14 examinations. Is this a document that  
02:39:31 15 you've seen before?

02:39:32 16 A. Yes.

02:39:32 17 Q. In the introduction they talk  
02:39:33 18 about the purpose of a post-mortem  
02:39:36 19 investigation. And they lay out one of the  
02:39:41 20 purposes at number 4 as, "To address  
02:39:44 21 relevant medico-legal issues." I suppose  
02:39:49 22 my first question is as a local corner what  
02:39:51 23 is your understanding of a relevant  
02:39:53 24 medico-legal issue.

02:39:56 25 A. If there are family concerns,  
02:39:58 26 if there's some sort of suspicion, or if  
02:39:59 27 there's foul play suspected, or if it's a  
02:40:01 28 work-related accident or something of that  
02:40:04 29 nature.

02:40:04 30 Q. But that -- to your mind that  
02:40:05 31 would have to be something expressly  
02:40:08 32 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 1 MS. BAMBERS: So there was, the  
02:41:12 2 records show, hypoglycemia but  
02:41:14 3 he's making an assumption that the  
02:41:16 4 source was exogenous insulin. The  
02:41:18 5 person investigating wouldn't know  
02:41:20 6 what the cause of the hypoglycemia  
02:41:23 7 is.

02:41:24 8 Your question was?

02:41:27 9 MR. VAN KRALINGEN: Quite frankly  
02:41:28 10 I can't remember my question. I'm  
02:41:29 11 going to try again and avoid any  
02:41:31 12 concern.

02:41:32 13 THE COMMISSIONER: Okay. Thank  
02:41:32 14 you.

02:41:33 15 BY MR. VAN KRALINGEN:

02:41:33 16 Q. I'll go back to my earlier  
02:41:36 17 question and we'll build from there if  
02:41:37 18 that's all right.

02:41:37 19 Could an unexplained, severe  
02:41:38 20 hypoglycemia in a resident who is nondiabetic  
02:41:44 21 constitute a relevant medico-legal issue at  
02:41:47 22 the time of death?

02:41:49 23 A. It could.

02:41:50 24 Q. It could?

02:41:50 25 A. Yes.

02:41:51 26 Q. Do you think it's important  
02:41:52 27 for an investigating local coroner to  
02:41:55 28 determine the source of that unexplained,  
02:41:57 29 severe hypoglycemia?

02:42:00 30 A. So I think we need to qualify  
02:42:02 31 that. So is the -- is the hypoglycemia  
02:42:06 32 prolonged? Repeated? Or just solitary?

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Q. That's a fair question. My question is does it bear investigation I suppose as a first --

A. If it's solitary and it's corrected I don't think so.

Q. Can you go to the next tab, second page within this -- no. The second page within this tab, yes.

There's reference within this best practice guideline to a post-mortem examination ordering decision tool. Have you seen that before?

A. Yes.

Q. And what's your best understanding of the purpose of that decision tool?

A. The post-mortem examination is at the discretion of the attending coroner provided, you know, there's no obvious cause or you're at a loss for a reasonable cause of death in a patient.

Q. All right. Can you go to tab 9 of the document you have? It's document 69319. This is actually a copy of the examination ordering decision tool itself?

A. Uhm hmm.

Q. And, again, you've seen this document before and you've used the document in your coroners practice?

A. Yes.

Q. Could you cycle down to page 2 please at the bottom? Page 2 has a



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

02:45:05 1 MR. HUBBARD: Commissioner, I'm  
02:45:07 2 sorry but I rise. This is not an  
02:45:10 3 appropriate line of questioning.  
02:45:11 4 He can certainly, as my friend was  
02:45:13 5 doing, ask what Dr. George  
02:45:14 6 understood and believed at the  
02:45:16 7 time, but in terms of what the  
02:45:17 8 actual cause of death was in this  
02:45:19 9 particular case that's for someone  
02:45:20 10 else, not Dr. George looking back.  
02:45:23 11 There'll be experts during another  
02:45:26 12 phase of this Inquiry. I don't  
02:45:27 13 know that it's particularly in  
02:45:29 14 dispute but we're now wandering  
02:45:31 15 outside of this witness' area of  
02:45:32 16 involvement and expertise.

02:45:34 17 BY MR. VAN KRALINGEN:

02:45:34 18 Q. That's fine, let's go to tab  
02:45:36 19 10 of the documents you have in front of  
02:45:36 20 you. This is the Institution Patient Death  
02:45:37 21 Record, 65223. My first question is -- page  
02:45:52 22 7.

02:45:59 23 My first question is, I'm unclear  
02:46:00 24 as to how often you encounter this form or  
02:46:04 25 what facility you have with this form?

02:46:07 26 A. The Institutional Patient  
02:46:07 27 Death Record?

02:46:08 28 Q. Yes. Do you ever see it?

02:46:11 29 A. Yes, I've seen it before.

02:46:13 30 Q. Okay.

02:46:20 31 A. I'll see it at the same  
02:46:21 32 time -- when I'm going to a nursing home to

02:46:22 1 do a death investigation I usually see this  
02:46:25 2 form.

02:46:25 3 Q. I see.

02:46:25 4 You'll see that Ms. Routledge  
02:46:27 5 completes it. This is the form with respect  
02:46:29 6 to Ms. Pickering and Ms. Routledge completes  
02:46:31 7 it?

02:46:31 8 A. Yes.

02:46:32 9 Q. And she completes all  
02:46:33 10 "no's", do you see that?

02:46:36 11 A. Yes.

02:46:36 12 Q. My question is, if she's  
02:46:38 13 completed these as all as "no's" do you  
02:46:41 14 know why you were called?

02:46:42 15 A. Central dispatch put through  
02:46:45 16 the call as there was some concern.

02:46:47 17 Q. And do you know why central  
02:46:49 18 dispatch was called if Ms. Routledge  
02:46:52 19 completed this as all "no"? You don't?

02:46:56 20 A. I don't.

02:46:59 21 Q. Do you know if you talked  
02:47:01 22 with Ms. Routledge before she completed the  
02:47:04 23 Institutional Patient Death Record?

02:47:05 24 A. I don't recall.

02:47:06 25 Q. If a local coroner doesn't  
02:47:15 26 keep notes and doesn't send in a Case  
02:47:16 27 Selection Data Form, and the long-term care  
02:47:19 28 home only answers "no" on the Institutional  
02:47:21 29 Patient Death Record, you'll agree with me  
02:47:25 30 that there's nobody from either the Regional  
02:47:26 31 Senior Coroners Office, or the Office of the  
02:47:28 32 Chief Coroner who would ever know that there

02:47:31 1 was ever a consideration of investigating a  
02:47:33 2 particular death?

02:47:35 3 A. The family physician -- the  
02:47:36 4 attending physician would have been aware of  
02:47:39 5 that as well.

02:47:45 6 Q. Can you go to tab 11 of the  
02:47:46 7 document you have before you? I apologize,  
02:47:48 8 can you go to tab 14. I said we would  
02:47:50 9 bounce around a little bit.

02:47:52 10 This is document 71986. This is  
02:47:57 11 the record from Ms. Kelly's dispatch. And  
02:48:12 12 what you'll see is over the next three pages  
02:48:14 13 the box in the middle there is actually where  
02:48:17 14 the narrative is captured, and because the  
02:48:19 15 narrative is larger than the box we've  
02:48:19 16 printed out a number of pages to capture the  
02:48:25 17 full narrative.

02:48:25 18 The narrative from Ms. Kelly says:  
02:48:26 19 "Went to the hospital, found to  
02:48:27 20 have had low blood sugar.

02:48:30 21 Dr. Urbantke, one of our coroners,  
02:48:30 22 advised the nursing home to call  
02:48:33 23 this case in once she dies. Not  
02:48:35 24 sure if there is more to it or  
02:48:37 25 not."

02:48:37 26 Let's go to the next page.

02:48:37 27 "Hospital two days ago, spoke to  
02:48:44 28 Dr. Urbantke, the coroner, and she  
02:48:46 29 said that the blood sugar was less  
02:48:49 30 than 1 and was unexplained. She  
02:48:51 31 can't take the case because she saw  
02:48:52 32 her in the ER but will speak to the

02:48:55 1 coroner to give more background  
02:48:57 2 information."  
02:48:57 3 To be fair to you my understanding  
02:48:59 4 is you don't have an independent recollection  
02:49:00 5 of a conversation with dispatch about this  
02:49:02 6 case, is that fair to say?  
02:49:04 7 A. That's fair to say.  
02:49:05 8 Q. Sitting here today though you  
02:49:07 9 don't dispute that this information was  
02:49:08 10 conveyed to you, is that fair to say?  
02:49:10 11 A. That's fair to say.  
02:49:17 12 Q. Go back to the first page  
02:49:18 13 please. It says:  
02:49:23 14 "Dr. Urbantke advised the nursing  
02:49:27 15 home to call this case in once she  
02:49:30 16 dies."  
02:49:30 17 It doesn't speak to the timeframe  
02:49:32 18 between when she was in the hospital and when  
02:49:34 19 she dies, you'll agree with that?  
02:49:37 20 A. That's correct, but it does  
02:49:38 21 on the second page. It says "two days  
02:49:40 22 earlier" but that's incorrect.  
02:49:42 23 Q. That's fair but my comment  
02:49:44 24 was about what Dr. Urbantke had advised?  
02:49:48 25 A. That's right.  
02:49:48 26 Q. And you'll agree with me that  
02:49:48 27 she didn't speak to a time limitation for  
02:49:50 28 when the coroner should be called?  
02:49:53 29 I'm sorry, you have to verbalize  
02:49:53 30 your answer.  
02:49:54 31 A. Okay.  
02:49:58 32 Q. My read of this note is that

02:49:59 1 Dr. Urbantke would have taken the call if  
02:50:03 2 she did not have a conflict as the treating  
02:50:05 3 doctor, is that your read of it?

02:50:07 4 A. I can't say -- speak for  
02:50:10 5 Dr. Urbantke.

02:50:22 6 Q. Go to tab 16 of the documents  
02:50:23 7 you have before you. I apologize, document  
02:50:33 8 71446. This document is called "A Narrative  
02:50:44 9 Template for Corners", and my understanding  
02:50:46 10 is that its purpose is to assist a coroner  
02:50:48 11 in completing a Form 3, is that accurate?

02:50:51 12 A. That's correct.

02:50:51 13 Q. Have you seen this document  
02:50:53 14 before?

02:50:53 15 A. Yes.

02:50:54 16 Q. And do you use this document  
02:50:55 17 in the course of your usual practice?

02:50:57 18 A. Yes.

02:50:59 19 Q. You've indicated today that  
02:51:00 20 you will speak with family members when  
02:51:02 21 those family members are available, is that  
02:51:04 22 fair to say?

02:51:05 23 A. That's fair to say.

02:51:07 24 Q. And Dr. Mann discussed a best  
02:51:09 25 practice to provide a pamphlet or perhaps  
02:51:13 26 contact details, and you've indicated that  
02:51:14 27 you provide contact details to family  
02:51:17 28 members at least, is that right?

02:51:20 29 A. That's correct.

02:51:20 30 Q. Are you authorized -- let's  
02:51:22 31 go to the third page as a starting point.  
02:51:25 32 At the top of the third page please.

1                   There's a discussion with  
2 communication of next of kin or legal  
3 representatives and under the "Necessary  
4 Elements" it says:

5                   "It is mandatory to speak to the  
6 next of kin, legal representative  
7 or substitute decision maker  
8 regarding the death."

9                   My question to you is, do you deem  
10 it to be mandatory to speak to the next of  
11 kin, legal representative or substitute  
12 decision maker assuming that they are  
13 reasonably available?

14                  A.    Yes.

15                  Q.    And are you authorized in any  
16 way to delegate that authority to another  
17 healthcare practitioner?

18                  A.    No.

19                  Q.    So you have to be the one who  
20 speaks to the family member?

21                  A.    That's correct.

22                  Q.    And if you didn't speak to a  
23 family member at any given point it would be  
24 a breach of your obligations?

25                  A.    It may have occurred, I don't  
26 recall.

27                  Q.    Can you go to tab 18 of the  
28 document you have before you? This is  
29 document 65227.

30                  This is the coroners investigation  
31 Form 3 relating to Mr. Silcox. If you can  
32 cycle down to the narrative on the bottom?

02:52:50 1 So you've just indicated to me that  
02:52:52 2 you're not really supposed to delegate the  
02:52:54 3 authority to speak to a family member to  
02:52:56 4 another healthcare practitioner?

02:52:58 5 A. That's correct.

02:52:59 6 Q. But you don't have an  
02:53:00 7 independent recollection of any conversation  
02:53:02 8 with Mr. Silcox's family?

02:53:04 9 A. I don't recall.

02:53:06 10 Q. And so what is your response  
02:53:07 11 to Mr. Silcox's family, and in particular  
02:53:11 12 his power of attorney who says that she  
02:53:14 13 never spoke with you and no member of her  
02:53:17 14 family who was present at the home that day  
02:53:19 15 spoke with you?

02:53:20 16 A. I don't recall.

02:53:31 17 Q. Can you go to tab 11 of the  
02:53:33 18 documents you have? And this is the section  
02:53:43 19 of the transcript, June 13, 2018, I'm going  
02:53:49 20 to ask you to look past two of the blue  
02:53:53 21 pages.

02:53:54 22 Could you cycle down starting at  
02:54:21 23 question 19 -- line 19? To give you some  
02:54:30 24 context, Dr. George, there was a  
02:54:32 25 cross-examination of Karen Routledge earlier  
02:54:34 26 in these proceedings.

02:54:38 27 Starting at line 19 the question  
02:54:40 28 was:

02:54:41 29 "QUESTION: My understanding is  
02:54:41 30 that upon Ms. Pickering's death you  
02:54:43 31 had a conversation with Dr. George?

02:54:45 32 "ANSWER: Yes.



02:54:46 1 "QUESTION: Specifically because  
02:54:46 2 Dr. Urbantke, as documented in the  
02:54:46 3 progress notes, suggested a call to  
02:54:50 4 the coroner?

02:54:51 5 "ANSWER: Yes."

02:54:52 6 I ask her to recall everything she  
02:54:57 7 can about that conversation with Dr. George,  
02:54:59 8 and I intentionally sort of asked an open  
02:55:01 9 question, just so you know.

02:55:01 10 Her answer starts at the bottom of  
02:55:02 11 that page. It says:

02:55:03 12 "ANSWER: I called the coroners  
02:55:04 13 office the 1-800 number and he  
02:55:07 14 called back. And I passed on the  
02:55:08 15 information that this lady had been  
02:55:10 16 seen yesterday in emerg regarding  
02:55:12 17 concerns I had about her condition  
02:55:15 18 and that they had discovered an  
02:55:15 19 unexplained extremely low blood  
02:55:19 20 sugar"

02:55:19 21 "QUESTION: Okay. Dr. George, in  
02:55:22 22 the face of that -- did Dr. George  
02:55:24 23 talk to you about the reason why he  
02:55:25 24 was not going to attend?

02:55:26 25 "ANSWER: No. I also talked about  
02:55:31 26 co-morbidities and the possibility  
02:55:33 27 that she may have had a stroke and  
02:55:35 28 we reviewed her medical history."

02:55:38 29 I assume sitting here today you  
02:55:40 30 have nothing to dispute that recollection?

02:55:42 31 A. No.

02:55:43 32 Q. I'm sorry?

02:55:44 1 A. Yes.

02:55:45 2 Q. You've got nothing to dispute

02:55:46 3 that recollection?

02:55:47 4 A. Nothing to dispute that.

02:55:52 5 Q. And so we're very comfortable

02:55:54 6 that you knew about the extremely low blood

02:55:57 7 sugar that Dr. Urbantke was concerned about

02:55:59 8 as of the date you were called with respect

02:55:59 9 to this possible death investigation?

02:56:03 10 A. That's correct.

02:56:04 11 Q. Can we go to next document

02:56:05 12 which is --

02:56:06 13 A. However it wasn't the day

02:56:07 14 before, the low blood sugar.

02:56:10 15 Q. I didn't say it was the day

02:56:11 16 before?

02:56:11 17 A. On the transcript it is.

02:56:13 18 Q. I understand.

02:56:25 19 MS. FRAZER: It's getting very

02:56:27 20 difficult to hear back here.

02:56:29 21 THE COMMISSIONER: I do think we

02:56:30 22 should just clarify this point

02:56:31 23 because it's come up several times

02:56:33 24 in the examination.

02:56:34 25 So, Dr. George, you're saying it

02:56:41 26 wasn't the day before?

02:56:44 27 THE WITNESS: It wasn't.

02:56:45 28 THE COURT: So you are disputing

02:56:47 29 what -- because counsel just put

02:56:50 30 to you, do you have any reason to

02:56:52 31 dispute what Karen Routledge said

02:56:54 32 to you?

02:56:59 1 BY MR. VAN KRALINGEN:

02:56:59 2 Q. Well, let's be clear. That  
02:57:00 3 Karen Routledge said this to you. That  
02:57:04 4 Karen Routledge said this to you. What the  
02:57:05 5 actual fact of the events were is a separate  
02:57:09 6 question.

02:57:10 7 THE COMMISSIONER: Okay. So were  
02:57:10 8 you answering his question?

02:57:12 9 THE WITNESS: Okay. I understand  
02:57:14 10 that.

02:57:14 11 THE COMMISSIONER: And you are  
02:57:15 12 answering his question?

02:57:17 13 THE WITNESS: Differently.

02:57:18 14 THE COMMISSIONER: You're saying  
02:57:18 15 that if Karen Routledge testified  
02:57:20 16 here in the Inquiry that she told  
02:57:22 17 you this thing you have no reason  
02:57:23 18 to --

02:57:24 19 THE WITNESS: No reason not to  
02:57:26 20 believe that.

02:57:27 21 THE COMMISSIONER: Okay.

02:57:27 22 BY MR. VAN KRALINGEN:

02:57:27 23 Q. And you have no reason to  
02:57:29 24 dispute it because you have no independent  
02:57:31 25 recollection of the evidence.

02:57:31 26 A. No.

02:57:31 27 MR. HUBBARD: Sorry, I just need  
02:57:33 28 clarification then. Is it just  
02:57:33 29 the message that there was a  
02:57:34 30 concern raised and what they may  
02:57:35 31 have discussed as opposed to the  
02:57:37 32 issue of whether it was one day

02:57:39 1 post-visit to the ER, or five-days  
02:57:41 2 post-visit to the ER?  
02:57:44 3 MR. VAN KRALINGEN: It is  
02:57:44 4 absolutely the former not the  
02:57:46 5 latter.  
02:57:46 6 MR. HUBBARD: I think we're all  
02:57:48 7 agreed but it's important.  
02:57:50 8 THE COMMISSIONER: I do think it's  
02:57:51 9 important and that's why we're  
02:57:53 10 clear. This is what I understand,  
02:57:54 11 I understand that Karen Routledge  
02:57:57 12 testified before us that she told  
02:58:00 13 Dr. George about the concerns she  
02:58:03 14 had about her and said that it  
02:58:05 15 related to the day before; and  
02:58:11 16 Dr. George responded that he had  
02:58:12 17 no reason to dispute that  
02:58:13 18 statement because he has no  
02:58:18 19 independent recollection, but he  
02:58:20 20 added that factually the statement  
02:58:23 21 is correct. That's what I  
02:58:24 22 understand.  
02:58:25 23 THE WITNESS: Yes.  
02:58:27 24 MR. VAN KRALINGEN: That's also my  
02:58:28 25 understanding of the evidence as  
02:58:29 26 well.  
02:58:29 27 MR. HUBBARD: Thank you very much.  
02:58:31 28 BY MR. VAN KRALINGEN:  
02:58:31 29 Q. Because you have no  
02:58:32 30 independent recollection of these events you  
02:58:34 31 can't tell us how long you took to come to  
02:58:36 32 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

03:00:00 1 decision not to conduct a death  
03:00:02 2 investigation with respect to Ms. Pickering,  
03:00:04 3 correct?

03:00:05 4 A. That's correct.

03:00:06 5 Q. But you don't know what you  
03:00:07 6 did review, and we don't know what you did  
03:00:09 7 review for two reasons. First of all you  
03:00:11 8 had no contemporaneous notes, is that fair  
03:00:14 9 to say?

03:00:15 10 A. That's correct.

03:00:15 11 Q. And, second, you don't have  
03:00:17 12 an independent recollection?

03:00:18 13 A. No, I don't recall.

03:00:19 14 Q. Okay. Yesterday we heard  
03:00:23 15 from the chief -- but those documents that  
03:00:24 16 you're referring to that you would have  
03:00:26 17 reviewed are essentially the equivalent of  
03:00:29 18 medical records, is that fair to say?

03:00:31 19 A. That's correct.

03:00:31 20 Q. Yesterday we heard from the  
03:00:33 21 Chief Coroner of the Province that coroners  
03:00:35 22 are not legally allowed to look at medical  
03:00:38 23 records before choosing to undertake a death  
03:00:40 24 investigation, i.e., during the time when  
03:00:43 25 they're figuring out whether to conduct an  
03:00:45 26 investigation or not. It's actually  
03:00:48 27 something that he wants to fix.

03:00:49 28 So my question to you is, where  
03:00:51 29 would you have obtained the authority to  
03:00:53 30 review medical records in advance of deciding  
03:00:56 31 whether to conduct a death investigation for  
03:01:00 32 Ms. Pickering?

03:01:01 1 A. Through an electronic system,  
03:01:04 2 or through medical records from the  
03:01:06 3 hospital, or through a phone call to emerg.

03:01:09 4 Q. Well, you're talking to me  
03:01:10 5 about the process by which you would have  
03:01:12 6 got those documents. I'm asking you for  
03:01:14 7 your authority to obtain those documents in  
03:01:16 8 the circumstance?

03:01:18 9 A. I guess we're doing it and  
03:01:20 10 we're probably not supposed to be.

03:01:28 11 Q. You can't tell me today if  
03:01:29 12 you spoke to Dr. Urbantke or not can you?

03:01:34 13 A. I don't recall.

03:01:35 14 THE COMMISSIONER: Counsel, we'll  
03:01:35 15 take a brief pause for the Court  
03:01:35 16 Reporters to switch the audio.

03:01:35 17 MR. VAN KRALINGEN: Certainly.

03:01:35 18 -- RECESSED AT 3:01 P.M.

03:01:35 19 -- RESUMED AT 3:01 P.M.

03:02:05 20 MR. VAN KRALINGEN: Ms. Jones  
03:02:05 21 has actually just helped me with a  
03:02:05 22 clarification of Ms. Routledge's  
03:02:05 23 evidence with respect to the one  
03:02:05 24 day versus five day that -- just  
03:02:21 25 in the public interest, I think  
03:02:22 26 it's actually important to put on  
03:02:24 27 the record.

03:02:24 28 THE COMMISSIONER: Yes.

03:02:25 29 MR. VAN KRALINGEN: Looking at  
03:02:26 30 page 1407 of that same transcript.

03:02:28 31 THE COMMISSIONER: Do you want  
03:02:32 32 to pull it up?

03:02:34 1 MR. VAN KRALINGEN: If don't  
03:02:35 2 mind. This comes out of you her  
03:02:48 3 time, not my time; right?  
03:02:51 4 THE COMMISSIONER: Right.  
03:03:08 5 MR. VAN KRALINGEN: You don't  
03:03:09 6 have the full transcript. Go to  
03:03:22 7 1407, please. [AS READ]  
03:03:23 8 "I note that this conversation  
03:03:31 9 that you had with Dr. George was over four  
03:03:33 10 years ago or four years ago, and I think you  
03:03:35 11 were giving evidence today to my friend  
03:03:36 12 today that you told Dr. George that she had  
03:03:39 13 gone to the hospital yesterday?  
03:03:40 14 A. Yes.  
03:03:40 15 Q. So I think from the documents  
03:03:42 16 we're seeing, that was about five days  
03:03:43 17 earlier?  
03:03:44 18 A. Yes.  
03:03:44 19 Q. And I think it's  
03:03:46 20 understandable given the passage  
03:03:48 21 of time, you were just mistaken about  
03:03:50 22 exactly what you told Dr. George on the  
03:03:51 23 point that it was five days earlier, not  
03:03:53 24 yesterday?  
03:03:54 25 A. Correct.  
03:03:57 26 THE COMMISSIONER: Thank you.  
03:03:58 27 MR. VAN KRALINGEN: Thanks.  
03:03:59 28 BY MR. VAN KRALINGEN:  
03:04:00 29 Q. Can we go back to Tab 12 of  
03:04:02 30 the documents you have, and that's  
03:04:05 31 Document 65222. Thanks.  
03:04:09 32 On the bottom of the page, there



03:04:11 1 is a -- there's a note from Ms. Wettlaufer  
03:04:15 2 at 17:21. Do you see that?

03:04:17 3 A. Yes.

03:04:19 4 Q. So it's Dr. Urbantke  
03:04:19 5 mentioned that Maureen's blood sugar was  
03:04:23 6 extremely low when she arrived at the  
03:04:24 7 hospital, and the cause is unknown. She  
03:04:26 8 stated that if Maureen passes, it might be a  
03:04:29 9 good idea to call the coroner on this one.

03:04:33 10 Again, you'll agree with me that  
03:04:35 11 Dr. Urbantke, through the note that  
03:04:38 12 Ms. Wettlaufer documented, doesn't seem to  
03:04:40 13 put a time frame in terms of how long you  
03:04:45 14 should wait to call the coroner if  
03:04:48 15 Ms. Pickering dies? You'll agree with me on  
03:04:52 16 that?

03:04:52 17 A. But Ms. Pickering was  
03:04:54 18 palliative care. She was returned to the  
03:04:57 19 long-term care facility with -- you know,  
03:04:58 20 she was receiving hydromorphone on a regular  
03:05:05 21 basis.

03:05:05 22 Q. That's my very point. When  
03:05:06 23 she leaves, she's palliative, and we don't  
03:05:06 24 know how long she's going to live; correct?

03:05:08 25 A. That's correct. And that --  
03:05:10 26 you know, the word "if," if Maureen passes.  
03:05:12 27 So the implication of the word "palliative"  
03:05:15 28 means somebody is going to pass.

03:05:21 29 Q. In your experience as a local  
03:05:22 30 coroner, have you seen a note like this  
03:05:24 31 before where somebody who's a treating  
03:05:26 32 physician who also happens to be a coroner

03:05:28 1 provides a note to a long-term care home or  
03:05:30 2 other health facility that it might be a  
03:05:33 3 good idea to call a coroner if the patient  
03:05:36 4 dies?

03:05:38 5 A. We've had differences of  
03:05:38 6 opinion on occasions where one coroner may  
03:05:39 7 think something is a coroners case and  
03:05:41 8 another coroner thinks that it's not.

03:05:45 9 Q. That's not the question I  
03:05:45 10 asked you, but I appreciate the  
03:05:45 11 contribution. The question I asked you is  
03:05:47 12 have you ever seen a note like this before  
03:05:48 13 in a medical record of any sort?

03:05:51 14 A. No.

03:05:52 15 Q. Would you agree with me it's  
03:05:53 16 an unusual note?

03:05:54 17 A. It's an unusual note.

03:05:59 18 Q. We talked earlier today about  
03:06:00 19 your views that you did not believe a  
03:06:03 20 long-term care -- a caregiver at a long-term  
03:06:06 21 care facility would intentionally harm a  
03:06:08 22 resident?

03:06:09 23 A. I didn't think so.

03:06:11 24 Q. Do you think that that  
03:06:13 25 affected your approach with respect to the  
03:06:15 26 decisions, investigate or not investigate  
03:06:18 27 any given death in a long-term care home?

03:06:20 28 A. I didn't suspect foul play.

03:06:23 29 Q. That's not the question I  
03:06:24 30 asked you, though. The question I asked you  
03:06:25 31 was do you think the fact that you didn't  
03:06:27 32 suspect foul play affected your

03:06:29 1 decision-making process when considering  
03:06:31 2 whether to conduct or not conduct a death  
03:06:33 3 investigation of a long-term care resident?  
03:06:35 4 A. No.  
03:06:35 5 MR. VAN KRALINGEN: Thank you  
03:06:46 6 kindly for your time today. Those  
03:06:48 7 are my questions.  
03:06:50 8 THE COMMISSIONER: Thank you,  
03:06:51 9 Mr. Van Kralingen.  
03:07:01 10 MR. SCOTT: We have no additional  
03:07:02 11 questions.  
03:07:02 12 THE COMMISSIONER: Thank you,  
03:07:04 13 Mr. Scott.  
03:07:05 14 MS. JONES: Commissioner, I just  
03:07:08 15 canvassed the room, and I believe  
03:07:08 16 the only counsel currently who has  
03:07:12 17 questions in cross-examination is  
03:07:15 18 Ms. Fraser on behalf of the  
03:07:20 19 Ontario Association of Residents'  
03:07:20 20 Councils.  
03:07:22 21 THE COMMISSIONER: Thank you  
03:07:22 22 very much.  
03:07:23 23 MS. FRAZER: Thank you.  
03:07:24 24 THE COMMISSIONER: Ms. Frazer.  
03:07:26 25 CROSS-EXAMINATION BY MS. FRAZER:  
03:07:26 26 Q. Sir, my name is Suzan Fraser.  
03:07:57 27 I'm here on the behalf of the Ontario  
03:07:17 28 Association of Residents' Councils. Do you  
03:08:01 29 know what a Residents' Council is?  
03:08:03 30 A. Yes.  
03:08:03 31 Q. Okay. So you understand that  
03:08:04 32 each long-term care home has a mandated

03:08:08  
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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 1 A. I don't think.

03:08:59 2 Q. You would know Dr. Fernando

03:09:01 3 who was a psychiatrist?

03:09:02 4 A. Yes.

03:09:03 5 Q. I understand he was

03:09:05 6 Ms. Wettlaufer's psychiatrist, among other

03:09:06 7 people?

03:09:06 8 A. I didn't know that.

03:09:07 9 Q. You did not know that.

03:09:08 10 And Dr. Brio we've heard of?

03:09:15 11 A. Yes.

03:09:16 12 Q. You knew him. Okay.

03:09:17 13 And so when somebody died in a

03:09:21 14 long-term care home and you were familiar

03:09:21 15 with the person professionally from your

03:09:21 16 work sharing privileges at the hospital, did

03:09:29 17 you ever decline a case by view of it being

03:09:34 18 a conflict?

03:09:35 19 A. I can't recall. I may have.

03:09:36 20 Q. Okay. You can't think of a

03:09:38 21 specific example?

03:09:38 22 A. No.

03:09:39 23 Q. Okay. And certainly, you

03:09:43 24 didn't think Dr. Urbantke in the case

03:09:46 25 involving Ms. Pickering thought that she had

03:09:49 26 a conflict, but you didn't think it was a

03:09:51 27 conflict to perform -- decide whether it was

03:09:55 28 a coroners investigation or not?

03:09:56 29 A. That's correct.

03:09:56 30 Q. Okay. Just turning, then, to

03:10:04 31 your jurisdiction and your legislative

03:10:08 32 authority, you understand that when you are

03:10:11 1 acting as a coroner dispatched to a  
03:10:16 2 long-term care home, that you're performing  
03:10:19 3 a statutory function?  
03:10:20 4 A. Yes.  
03:10:21 5 Q. Okay. And that your work is  
03:10:22 6 guided by statute?  
03:10:23 7 A. That's right.  
03:10:24 8 Q. All right. That you can only  
03:10:25 9 do what the statute tells you to do?  
03:10:28 10 A. That's correct.  
03:10:29 11 Q. Or gives you -- what --  
03:10:30 12 authorizes you to do?  
03:10:33 13 A. What the authority is, yes.  
03:10:34 14 Q. Right. Okay. And you  
03:10:36 15 understand that -- you've talked about the  
03:10:44 16 process in which you're forming an opinion  
03:10:46 17 about whether you're going to investigate or  
03:10:48 18 not; right?  
03:10:48 19 A. That's correct.  
03:10:49 20 Q. And you understand that in  
03:10:51 21 cases of long-term care, that you have broad  
03:10:54 22 authority to investigate?  
03:10:56 23 A. That's correct.  
03:10:56 24 Q. Right. That you're guided by  
03:10:59 25 Subsection 2.1 of Section 10 of the Coroners  
03:11:03 26 Act?  
03:11:05 27 A. The Coroners Act, yes.  
03:11:06 28 Q. Okay. So you're not limited  
03:11:09 29 to whether there's a sudden or unexpected  
03:11:11 30 death in terms of deciding to investigate?  
03:11:14 31 A. That's correct.  
03:11:14 32 Q. Okay. So how do you, as a

03:11:16 1 coroner, decide to exercise your discretion?  
03:11:19 2 What are the special considerations that you  
03:11:21 3 use in 2.1?

03:11:24 4 A. There would have to be some  
03:11:26 5 sort of extenuating circumstances where I  
03:11:28 6 would, you know, investigate it and turn it  
03:11:31 7 into a coroners case.

03:11:32 8 Q. Okay. And so in terms of  
03:11:36 9 examining those extenuating circumstances,  
03:11:37 10 do you ever look towards what particular  
03:11:39 11 policy issues or whether manuals have been  
03:11:42 12 complied with, anything like that?

03:11:44 13 A. Not specifically.

03:11:46 14 Q. Okay. You don't look to  
03:11:47 15 patient management guides or protocols?

03:11:51 16 A. Not at the nursing home.

03:11:52 17 Q. Okay. What about safety  
03:11:56 18 procedures or staff training? Do you ever  
03:12:00 19 look at those circumstances?

03:12:01 20 A. No.

03:12:01 21 Q. No?

03:12:01 22 A. Not unless they were brought  
03:12:03 23 to my attention.

03:12:03 24 Q. Right. And the only time in  
03:12:05 25 that period of time where you're forming an  
03:12:07 26 opinion about whether to investigate, you  
03:12:09 27 wouldn't actually have access to all those  
03:12:12 28 things?

03:12:12 29 A. No, I wouldn't.

03:12:12 30 Q. Okay. So you're limited in  
03:12:13 31 forming that opinion to the information that  
03:12:17 32 is readily and legally available to you?

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A. That's correct.

Q. And you'll agree with me that that -- in terms of what the Coroners Act provides, you have much greater powers once you issue a warrant to seize information; is that fair?

A. Or warrant to take possession of the remains.

Q. Right. So you have two things that you can do: You can issue your warrant for a postmortem examination. You can also issue warrants to seize records; right?

A. Warrant to take possession, not warrant for postmortem examination.

Q. Warrant to take possession of the body?

A. That's right.

Q. Okay. So in the consideration of extenuating circumstances in long-term care, you've already told us that you did not at the time believe that a caregiver would intentionally harm -- a health practitioner would intentionally harm a patient?

A. I had no reason to believe that.

Q. Okay. And would you agree with me that -- well, it's not a no reason to believe, but you actually did not believe that health care practitioners would harm patients?



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A. That's correct.

Q. Right. And so I'm going to suggest to you that your mind was closed to the possibility --

A. On the contrary.

Q. Okay. Let me just finish my question.

I'm suggesting to you that your mind was closed to the possibility that health care practitioners would harm a patient because of your personal beliefs?

A. I didn't suspect that a health care practitioner in a long-term care facility would harm a patient.

Q. Okay. Now, you understand that; right? That's possible?

A. That is possible.

Q. Okay. But during the period of time between you were acting as a coroner from 2004 to the disclosure of Ms. Wettlaufer's offences in 2016, did you not ever hear a story of a caregiver working in long-term care harming a resident?

A. I think there were some in the news where patients were being abused by staff.

Q. Yes, but that didn't affect your view?

A. No, it didn't.

Q. All right. So in the period of time following the elimination of the one in ten deaths, have you ever been called to

03:15:20 1 give an opinion about whether it ought to  
03:15:26 2 become a coroners investigation under  
03:15:29 3 Section 2.1 of the Coroners Act?

03:15:31 4 A. I can't recall recently.

03:15:34 5 Q. So you can't remember whether  
03:15:36 6 you were called, and we know that you  
03:15:39 7 haven't done an investigation?

03:15:40 8 A. I haven't been to -- I  
03:15:42 9 haven't done a nursing -- a long-term care  
03:15:45 10 facility coroners case in quite some time,  
03:15:47 11 and I don't recall receiving a phone call  
03:15:49 12 asking me.

03:15:51 13 Q. Okay. I have some questions  
03:15:52 14 about the conference that you went to in  
03:15:54 15 November, the coroners conference.

03:15:56 16 A. That's right.

03:15:56 17 Q. Was that a coroners  
03:15:58 18 conference organized by the Office of the  
03:16:00 19 Chief Coroner, or was that conference  
03:16:04 20 organized by the Ontario Coroners  
03:16:05 21 Association?

03:16:06 22 A. No, by the Office of the  
03:16:08 23 Chief Coroner.

03:16:09 24 Q. Okay. And are you a member  
03:16:10 25 of the Ontario Coroners Association?

03:16:12 26 A. No.

03:16:13 27 Q. No. Are you familiar with  
03:16:13 28 the Ontario Coroners Association?

03:16:12 29 A. Yes.

03:16:16 30 Q. Okay. Have you had any  
03:16:24 31 familiarization with any other death  
03:16:26 32 investigation model? Because I know you did

03:16:28 1 some training overseas.

03:16:30 2 A. Right.

03:16:30 3 Q. So a medical examiner model,  
03:16:33 4 other models of death investigation?

03:16:35 5 A. I lived in B.C., and in  
03:16:36 6 British Columbia, you didn't have to be a  
03:16:39 7 physician in order to be a coroner.

03:16:40 8 Q. Okay. Can you tell us just  
03:16:44 9 briefly about your experience with that  
03:16:45 10 model?

03:16:47 11 A. I was on a military base, and  
03:16:49 12 a civilian had died on military property, so  
03:16:53 13 it created some concern.

03:16:54 14 The coroner ran a delicatessen  
03:16:55 15 somewhere about 50 miles away, and it took  
03:17:00 16 him several hours to get there, and the  
03:17:03 17 elderly lady passed away. She was in our  
03:17:05 18 morgue.

03:17:05 19 The bag was taped up, and then she  
03:17:09 20 was transferred down to Campbell River on  
03:17:13 21 Vancouver island for a further assessment by  
03:17:18 22 a physician coroner.

03:17:20 23 Q. I see. Okay. So in that --  
03:17:20 24 just the way that you said ran a  
03:16:58 25 delicatessen, I didn't think that you  
03:17:24 26 thought highly of that particular model.

03:17:27 27 A. No, it's not that I didn't  
03:17:28 28 think highly. I was just rather shocked.  
03:17:29 29 That's the first time I'd heard that, you  
03:17:31 30 know, a nonphysician, a nonmedical person  
03:17:37 31 was that.

03:17:37 32 But he was actually quite

03:17:39 1 knowledgeable, and, you know, he was there  
03:17:40 2 to investigate a death, and she had died on  
03:17:43 3 Crown property.

03:17:44 4 Q. All right. So he actually  
03:17:45 5 did have some knowledge about how to conduct  
03:17:48 6 an investigation?

03:17:49 7 A. Right. He had been doing it  
03:17:51 8 for a number of years.

03:17:51 9 Q. Right. Okay.

03:17:55 10 MS. FRAZER: Sir, those are my  
03:17:56 11 questions for today. Thank you  
03:17:57 12 very much.

03:17:58 13 THE COMMISSIONER: Thank you,  
03:17:59 14 Ms. Fraser.

03:18:14 15 MS. JONES: Commissioner, if we  
03:18:15 16 can take the afternoon recess now  
03:18:18 17 just so that my friends can  
03:18:22 18 determine whether or not there  
03:18:23 19 will be a reexamination. I think  
03:18:25 20 that would be helpful.

03:18:26 21 THE COMMISSIONER: Yes, I don't  
03:18:27 22 have any problem with that. May I  
03:18:30 23 invite all of you to consider  
03:18:33 24 carefully whether there needs to  
03:18:35 25 be any reexamination on that  
03:18:37 26 one-day, five-day, two-day  
03:18:37 27 business?

03:18:40 28 MS. JONES: Okay. Thank you.

03:18:55 29 THE REGISTRAR: This Public  
03:19:21 30 Inquiry is in recess for 15  
03:19:27 31 minutes.

03:19:29 32 -- 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 1 A. It would have different  
03:40:40 2 implications. I mean, her blood sugar was  
03:40:42 3 -- the low blood sugar was five days  
03:40:44 4 earlier, and it would have been different if  
03:40:49 5 she had had a low blood sugar and then  
03:40:52 6 passed away very suddenly as a result of,  
03:40:55 7 you know, persistently low blood sugar.

03:40:58 8 This was a solitary event, as far  
03:41:01 9 as I can see, and she responded to several  
03:41:06 10 intravenous injections of some glucose.

03:41:09 11 Q. So is it your belief today  
03:41:11 12 that you would have known that it was five  
03:41:13 13 days previously that Ms. Pickering had had  
03:41:15 14 low blood sugar?

03:41:16 15 A. Yes.

03:41:17 16 MS. JONES: Thank you. I have no  
03:41:19 17 further questions, Commissioner.

03:41:21 18 THE COMMISSIONER: Thank you  
03:41:21 19 very much. That's helpful. So  
03:41:23 20 that's everything for Dr. George?

03:41:27 21 Yes. Thank you very much.

03:41:29 22 Sorry, I almost called you by the wrong  
03:41:31 23 doctor's name. Thank you so much for coming  
03:41:33 24 in. We know that testifying at inquiries is  
03:41:34 25 not the most pleasant experience for  
03:41:37 26 everybody, but we appreciate your help very  
03:41:40 27 much.

03:41:41 28 THE WITNESS: It's necessary.

03:41:41 29 THE COMMISSIONER: It is.

03:41:42 30 Thank you, Dr. George.

03:41:46 31 MS. JONES: Thank you,

03:41:47 32 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 1 MR. VAN KRALINGEN: Neither am I  
03:42:42 2 right now. We'll figure it out,  
03:42:44 3 though.  
03:42:44 4 THE COMMISSIONER: Oh, okay.  
03:42:44 5 All right. That was --  
03:42:45 6 MS. JONES: If Ms. Crawford is  
03:42:47 7 called, it would most likely be on  
03:42:49 8 Monday, and we can do that, I  
03:42:51 9 expect, relatively quickly, but we  
03:42:53 10 should have an update for you,  
03:42:56 11 Commissioner, and perhaps as early  
03:42:57 12 as tomorrow.  
03:42:58 13 THE COMMISSIONER: All right.  
03:42:59 14 That's fine. I'm not pressing you  
03:43:01 15 on that. That was my bit of  
03:43:03 16 confusion about the lineup and  
03:43:05 17 where we were going with that.  
03:43:06 18 Thank you very much.  
03:43:08 19 MS. JONES: Thank you.  
03:43:31 20 THE REGISTRAR: This Public  
03:43:32 21 Inquiry is adjourned until  
03:44:22 22 tomorrow at 9:30 a.m.  
03:44:35 23 --- Adjourned at 3:44 p.m.

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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.



NEESONS COURT REPORTING INC.

PER: HELEN MARTINEAU, CSR  
& CARISSA STABBLER, CSR, RPR

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