In the Matter Of:

The Long-Term Care Public Inquiry

DAY 21 / VOL 21

July 19, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 21/Volume 21 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 19th day of July, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

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

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

Rebecca Jones, Esq., & Laura Robinson, Esq.,	Commission Counsel
Jane Meadus, Esq., & Suzan E. Fraser, Esq.,	Ontario Association of Residents' Councils
David M. Golden, Esq.,	Caressant Care Nursing and Retirement Homes Limited, Caressant Care - Woodstock
Megan Schwartzentruber, Esq.	College of Nurses
Paul H. Scott, Esq.,	Jon Matheson, Pat Houde, Beverly Bertram
Rita Bambers, Esq., & Meagan Williams, Esq.,	Her Majesty the Queen in Right of Ontario

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

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

I N D E X

WITNESS: ELIZABETH URBANTKE

INDEX OF EXHIBITS

09:36:01 1 -- Proceedings commenced at 9:33 a.m. --
09:36:03 2 MS. ROBINSON: Good morning,
09:36:03 3 Commissioner.
09:36:04 4 THE COMMISSIONER: Good morning.
09:36:06 5 MS. ROBINSON: We're going to
09:36:07 6 begin this morning by calling
09:36:08 7 our next witness, Dr. Elizabeth
09:36:15 8 Urbantke.
09:36:15 9 THE COMMISSIONER: Thank you
09:36:16 10 very much.
09:37:17 11 MS. ROBINSON: Commissioner,
09:37:18 12 we'll be referring to the same
09:37:19 13 document brief that we were
09:37:21 14 referring to yesterday. If you
09:37:23 15 have that in front of you.
09:37:24 16 THE COMMISSIONER: I do.
09:37:25 17 Thank you.
09:37:25 18 ELIZABETH URBANTKE: SWORN.
09:37:25 19 EXAMINATION-IN-CHIEF BY
09:37:25 20 MS. ROBINSON:
09:37:26 21 Q. And, Dr. Urbantke, there's a
09:37:29 22 similar brief in front of you.
09:37:29 23 A. Yes.
09:37:29 24 Q. Dr. Urbantke, good morning.
09:37:29 25 A. Good morning.
09:37:29 26 Q. I'd like to begin by
09:37:31 27 understanding more about your background and
09:37:34 28 education leading to your appointment as an
09:37:37 29 investigating coroner in the province of
09:37:40 30 Ontario.
09:37:40 31 A. Okay.
09:37:40 32 Q. I'd like to start by

09:37:42 reviewing your CV.
09:37:46 MS. ROBINSON: Ms. Clewley, if
09:37:47 you could please pull up
09:37:49 Document 72835. And that's at
09:37:52 Tab 2 of the document brief.
09:37:52 BY MS. ROBINSON:
09:38:00 Q. So, Dr. Urbantke, I
09:38:01 understand that you're a physician licenced to
09:38:02 practice medicine in Ontario?
09:38:03 A. Correct.
09:38:04 Q. And based on your CV, I
09:38:05 understand that you graduated from medical
09:38:07 school in 1995?
09:38:07 A. Yes.
09:38:08 Q. Which medical school did you
09:38:10 attend?
09:38:10 A. University of Toronto.
09:38:11 Q. And that you subsequently
09:38:13 obtained residency training?
09:38:15 A. Yes.
09:38:15 Q. In what specialties?
09:38:16 A. Family practice and an extra
09:38:19 year in emergency medicine.
09:38:21 Q. When did you complete your
09:38:22 residency training?
09:38:23 A. 1998.
09:38:24 Q. And after that, in 1998, I
09:38:26 understand that you began practicing as an
09:38:30 emergency department physician?
09:38:31 A. Correct.
09:38:31 Q. And that was at the Woodstock
09:38:34 Hospital?

09:38:34 A. Yes.
09:38:34 Q. And have you continued to
09:38:38 work as an emergency room physician since that
09:38:41 time?
09:38:41 A. Yes.
09:38:41 Q. Have you worked in any other
09:38:43 hospitals other than the Woodstock Hospital?
09:38:45 A. Briefly at Stratford General.
09:38:48 Q. But the majority of your
09:38:49 practice for that period of time has been at
09:38:51 the Woodstock Hospital?
09:38:53 A. Correct.
09:38:54 Q. And based on your CV, I
09:38:56 understand that that includes a period of time
09:38:58 as the chief of emergency medicine?
09:38:59 A. Yes.
09:39:00 Q. And that was from 2012 to
09:39:02 2016?
09:39:02 A. Correct.
09:39:03 Q. And what was your role as the
09:39:05 chief of the emergency medicine department?
09:39:08 A. It's administrative role.
09:39:15 Scheduling was primarily a big part of it. I
09:39:17 oversaw learners coming into the emergency
09:39:20 department and also attending meetings and a
09:39:24 liaison with the nurse manager of the emergency
09:39:29 department and other areas in the hospital.
09:39:31 Q. And if you could turn to page
09:39:33 3 of your CV, please, under "Affiliations and
09:39:36 Memberships." I see that you are an executive
09:39:41 member of the Ontario Coroners Association?
09:39:44 A. Correct.

09:39:45 Q. What is your role as an
09:39:46 executive member of that organization?
09:39:47 A. My primary role in the past
09:39:51 few years has been assisting with the --
09:39:56 there's an annual spring conference,
09:39:59 educational conference for coroners that the
09:40:01 Ontario Coroners Association, or OCA, puts on.
09:40:06 And I've assisted in helping develop and run
09:40:09 that program.
09:40:10 Q. And backing up one step, what
09:40:12 is the Ontario Coroners Association?
09:40:14 A. It's a voluntary organization
09:40:17 of coroners, so a coroner does not have to be a
09:40:21 member of the Ontario Coroners Association.
09:40:23 Q. Does the organization have a
09:40:25 particular mandate or purpose?
09:40:27 A. I think it's varied over the
09:40:29 years. The past few years that I've been
09:40:32 involved has mostly been that educational
09:40:35 component. There is some dialogue with the
09:40:39 Office of the Chief Coroner to bring forth
09:40:42 coroners' views and if there is concerns.
09:40:49 MS. ROBINSON: Commissioner, I
09:40:50 propose that we mark
09:40:52 Dr. Urbantke's CV as the next
09:40:53 exhibit in this proceeding.
09:40:55 THE COMMISSIONER: All right.
09:40:55 Thank you. Madam Clerk, that's
09:40:58 exhibit --
09:41:01 THE REGISTRAR: 111.
09:41:03 THE COMMISSIONER: Exhibit 111
09:41:05 then, and that is the CV of

09:41:08 1 Elizabeth Urbantke.
09:41:07 2 EXHIBIT NO. 111: Curriculum
09:41:07 3 Vitae of Elizabeth Urbantke.
09:41:07 4 BY MS. ROBINSON:
09:41:15 5 Q. Dr. Urbantke, I understand
09:41:17 6 that in 2004, you began working as an
09:41:20 7 investigating coroner?
09:41:20 8 A. Correct.
09:41:21 9 Q. And your appointment as an
09:41:24 10 investigating coroner continues to present?
09:41:25 11 A. Yes.
09:41:26 12 Q. What region have you worked
09:41:29 13 in as a coroner?
09:41:30 14 A. It would be the west region.
09:41:36 15 Presently, I'm in the London office, so when I
09:41:39 16 started, my regional supervising coroner was
09:41:41 17 out of a Guelph office.
09:41:45 18 Q. Have you worked
09:41:46 19 geographically in the same area throughout your
09:41:46 20 time as a coroner?
09:41:47 21 A. Yes. Oxford County.
09:41:50 22 Q. What prompted you to become a
09:41:52 23 coroner?
09:41:52 24 A. Through my interactions with
09:41:55 25 coroners during -- if I had to call them as an
09:41:58 26 emergency physician and speaking to them about
09:42:01 27 their roles. And then there was a notice
09:42:07 28 posted in the doctors' lounge at the hospital
09:42:11 29 that -- asking for applications, "Are you
09:42:15 30 interested?" So I applied.
09:42:18 31 Q. Why have you continued to
09:42:20 32 work as a coroner since 2004?

09:42:21 A. I think it plays an important
09:42:27 role. So sort of in the short-term, it can
09:42:37 help give families closure and understanding,
09:42:41 but also the overall public -- like, a public
09:42:45 health safety role also.
09:42:50 The coroner's motto is we speak
09:42:52 for the dead to protect the living, so it's
09:42:55 that how do we prevent bad things happening.
09:43:03 Q. We've heard already in the
09:43:05 inquiry about the new coroners course at the
09:43:07 outset of your appointment as a coroner?
09:43:09 A. Okay.
09:43:10 Q. Did you attend the new
09:43:11 coroners course?
09:43:12 A. Yes, I did.
09:43:13 Q. Do you recall for how many
09:43:14 days the course lasted?
09:43:16 A. I don't -- I know I went to
09:43:19 Toronto for -- I'm going to say three to five
09:43:24 days. Beyond that, I can't tell you the exact
09:43:27 number of days.
09:43:28 Q. We've also heard that after
09:43:29 the new coroners course, a coroner is required
09:43:32 is undergo a period of mentorship?
09:43:36 A. Correct.
09:43:37 Q. Can you describe what that
09:43:39 mentorship process entailed for you?
09:43:42 A. Every time I had a call, I
09:43:43 would call the regional supervising coroner and
09:43:47 review the call, the death and my investigation
09:43:49 with her at that time.
09:43:50 Q. And do you recall for how

09:43:51 long that period of mentorship lasted?
09:43:55 A. Not exactly. It was
09:43:58 definitely months, but I can't recall.
09:44:02 Q. And with the new coroners
09:44:04 course and the period of mentorship, was there
09:44:10 any other training that you received before
09:44:12 commencing work as a coroner?
09:44:12 A. Not that I recall.
09:44:13 Q. And did you feel that the
09:44:15 course and that mentorship period appropriately
09:44:19 prepared you to start working as a coroner?
09:44:20 A. I think in combination, that
09:44:22 mentorship was -- it helped solidify what we
09:44:26 learned in the course.
09:44:27 Q. And since that initial
09:44:30 training period, have you engaged in ongoing
09:44:35 training or continuing medical education in
09:44:38 respect of death investigations, in particular?
09:44:39 A. I regularly attend -- the
09:44:43 Office of the Chief Coroner puts on annual
09:44:48 conferences in November or in the fall. I
09:44:53 regularly attend those unless I have a
09:44:56 conflict.
09:44:56 And then as I mentioned, the
09:44:58 Ontario Coroners Association does an annual
09:45:03 spring conference, and I would regularly attend
09:45:06 those, once again, unless there was a conflict
09:45:09 for some reason. And as I said, I've been
09:45:11 actually involved in developing the educational
09:45:15 programs for a few years.
09:45:16 And then there's been odd -- I'm
09:45:20 going to say one -- like, conferences here and

there that I've attended.

And I did do an online course -- I believe it was out of the University of North Dakota. I'm not even sure how it came to my attention -- on death investigation. So I thought it would be a good review. It was sort of, like, the basics, but I did do that.

Q. We've also heard about certain resources that the Office of the Chief Coroner provides to investigating coroners such as the coroners investigation manual and memoranda that are circulated on different topics related to death investigations?

A. Yes.

Q. We've heard that those are presently received electronically; is that correct?

A. Yes.

Q. When they're received, what is your practice in terms of reviewing them?

A. My practice would be to read them. And I will admit, I'm still a paper sort of person, so I do tend to print them out to have as a hard copy reference and then would save them for future reference, electronically save them as future. So I often have a hard copy and save the electronic version.

Q. And you said for future reference. Are those materials that you will refer to in the course of your coroner practice?

A. If I need to, yes.

09:46:39 Q. And what would be an example
09:46:42 of when you needed to?
09:46:43 A. I can't think of a specific
09:46:47 instance, but if I'm unsure of something, I
09:46:50 need to refresh my memory, I would go back to
09:46:53 it.
09:46:55 Q. And presently, as an
09:46:57 experienced investigating coroner, do you have
09:46:59 any ongoing mentorship with your regional
09:47:03 supervising coroner?
09:47:04 A. Not in the sense I have to
09:47:05 call in every time like I did when I was first
09:47:09 a coroner, but there was always a regional
09:47:13 supervising coroner on call. It might not
09:47:16 necessarily be my -- the one from my region,
09:47:18 but there's always someone available. So if I
09:47:22 have questions, I would call.
09:47:23 Q. We've already heard in the
09:47:29 inquiry about the process for a coroner being
09:47:31 contacted about a death in the province. I
09:47:35 want to understand for you. On average, how
09:47:38 many calls a month are you receiving from
09:47:41 provincial dispatch reporting a death?
09:47:43 A. It can actually vary quite a
09:47:50 bit. I know in the past, I averaged about 50
09:47:55 cases, like, for investigation cases a year,
09:48:02 but beyond that, I know -- I know I can go for
09:48:05 a week to two weeks without a call, and then I
09:48:08 can be called several days in a row. It --
09:48:10 I've been called couple times in a -- a day, so
09:48:13 it's hard to say.
09:48:14 Q. So you distinguish there

09:48:19 between being contacted --
09:48:19 A. Yeah.
09:48:20 Q. -- and accepting a case for
09:48:23 investigation?
09:48:23 A. Yes.
09:48:24 Q. So is it the case that there
09:48:26 are times when you're contacted about a case
09:48:28 that you will immediately decline?
09:48:31 A. I'm not -- well, I won't
09:48:36 decline to dispatch. I -- there's always an
09:48:40 initial, I guess you call, investigation that I
09:48:43 would contact the person calling dispatch.
09:48:45 Q. And I mean before that. For
09:48:48 instance, are there instances where you're not
09:48:50 available even to do that initial --
09:48:52 A. Yes.
09:48:52 Q. -- decision making?
09:48:54 A. Yeah, so if I get called and
09:48:57 I'm, say, right at the first part of my
09:49:00 emergency shift, I'm not able to leave my
09:49:03 shift, or I'm home in the middle of the night
09:49:04 with my kids and I'm not able to leave, I may
09:49:07 say I'm not available at that point in time.
09:49:09 Q. Are you able to speak to any
09:49:13 sense of the number of calls you receive from
09:49:15 dispatch versus the number of cases that you
09:49:17 accept to consider as a coroners case?
09:49:20 A. No, I can't.
09:49:21 Q. So I'm going to ask you a few
09:49:27 questions now to understand the process that
09:49:28 you go through in deciding whether or not you
09:49:32 should accept a case and commence a death

investigation in respect of that death.

THE COMMISSIONER: Just before you do that, Ms. Robinson, were you not going to help us get a sense of how many cases she might have dealt with over her career so far?

MS. ROBINSON: I had understood Dr. Urbantke's evidence to be about 50 cases a year.

BY MS. ROBINSON:

Q. Is that accurate, Dr. Urbantke?

A. That's what I was told in the past. I will say it's probably declined, but I can't give you a good number in the past years with my extra roles in administration, things like that. So being less available to do cases.

THE COMMISSIONER: Thank you. I just wasn't sure if that was for a period of time or that's basically since you became a coroner that you would say on average, about 50 cases a year that you dealt with.

THE WITNESS: That would -- I would submit, like, a full investigation.

THE COMMISSIONER: Okay. So there's a difference so. Those are the cases you've

09:50:31 1 investigated as opposed to ones
09:50:32 2 that you -- this is what I need
09:50:34 3 some help with. It's not clear
09:50:35 4 to me, and I'd appreciate it if
09:50:37 5 you could just give me a sense.
09:50:39 6 How many does she look at and
09:50:41 7 how many does she do an
09:50:42 8 investigation and so on; right?
09:50:46 9 MS. ROBINSON: Okay.
09:50:46 10 THE COMMISSIONER: Okay.
09:50:47 11 BY MS. ROBINSON:
09:50:47 12 Q. So are you able,
09:50:48 13 Dr. Urbantke, to give an estimate of the number
09:50:51 14 of calls you receive from provincial dispatch
09:50:54 15 in a month?
09:50:54 16 A. I can't give an accurate
09:50:57 17 estimate. Like I said, it can be quite
09:51:00 18 variable.
09:51:00 19 Q. And the next question, are
09:51:02 20 you able to give an estimate of how many cases
09:51:04 21 you accept to investigate in a month?
09:51:11 22 A. So if I accept to
09:51:12 23 investigate, that means I'm doing the full
09:51:15 24 investigation. That's -- as I said in the
09:51:16 25 past, it's been -- I've been told I do about an
09:51:20 26 average of 50, but I -- my perception is in the
09:51:23 27 past few years, it's probably less than that
09:51:25 28 because of my other roles I've taken on. I'm
09:51:29 29 less available to do those full investigations.
09:51:31 30 Q. And you said 50 in a year --
09:51:34 31 A. Yes.
09:51:34 32 Q. -- if I understand your

evidence?
THE COMMISSIONER: But those are death investigations.
THE WITNESS: The full death investigation.
THE COMMISSIONER: The full death investigation. So I guess I was trying to get a sense of -- obviously not every case that she accepts goes to a full death investigation, so I was trying to get a sense of how many she might do in a year, consider -- like, take the call from central dispatch, but make the determination that a death investigation was not warranted. There was no Section 10 criteria, for example.
BY MS. ROBINSON:
Q. Dr. Urbantke, I understand your evidence that you can't estimate the number of calls you receive from provincial dispatch in a month. Can you estimate the number of calls you receive from provincial dispatch in a year?
A. No. No, I can't. I think I understand -- you want to know how many cases I decline; is that --
THE COMMISSIONER: Right.
THE WITNESS: I can't -- I can't -- I can't tell you for

09:52:29 1 certain.
09:52:30 2 THE COMMISSIONER: Okay. So no
09:52:32 3 sort of sense of how many you
09:52:33 4 might decline as opposed to how
09:52:35 5 many you might proceed with?
09:52:40 6 THE WITNESS: I would say it can
09:52:40 7 be variable from -- depending on
09:52:42 8 the types of calls, so...
09:52:43 9 THE COMMISSIONER: That's
09:52:44 10 helpful. Thank you.
09:52:44 11 BY MS. JONES:
09:52:50 12 Q. Turning, then, to when you
09:52:51 13 received a call from dispatch. And you've
09:52:53 14 determined that you're in a position to make
09:52:54 15 that assessment as to whether it's a coroners
09:52:59 16 case: You're not on call; you're not home
09:53:01 17 alone with your kids.
09:53:02 18 At a high level, can you
09:53:03 19 describe your decision-making process for
09:53:06 20 evaluating if a case is properly a coroners
09:53:09 21 case?
09:53:09 22 A. So I would receive the
09:53:14 23 information from coroners dispatch, and then I
09:53:18 24 would contact whoever called in to coroners
09:53:21 25 dispatch for further information.
09:53:23 26 Q. Breaking that down, what
09:53:26 27 information do you receive from coroners
09:53:27 28 dispatch in the normal course?
09:53:29 29 A. In general, receive the name
09:53:32 30 of the deceased, although some circumstances
09:53:37 31 they may not have it. I will -- a brief
09:53:47 32 hospital summary, history of the death or

09:53:50 circumstances if they have it, and a contact
09:53:53 person, whoever called it in.
09:53:56 Q. And do you record that
09:53:58 information that you receive from dispatch in
09:54:00 any manner?
09:54:01 A. Yes.
09:54:01 Q. How do you record it?
09:54:03 A. Pen and paper.
09:54:05 Q. And is that information
09:54:07 retained in some respect?
09:54:08 A. Yes.
09:54:09 Q. And how do you retain that
09:54:11 information?
09:54:11 A. I have my files. I retain --
09:54:15 I retain those notes.
09:54:17 Q. And at that stage, when
09:54:20 you've received the demographic information and
09:54:23 the contact name from provincial dispatch,
09:54:25 would you ever make a decision then whether or
09:54:28 not a case is properly a coroners case?
09:54:30 A. No.
09:54:31 Q. So what do you do next then?
09:54:34 A. I would contact the contact
09:54:36 person.
09:54:36 Q. And why do you do that?
09:54:38 A. To get more information and
09:54:39 better understand the circumstances of the
09:54:42 death.
09:54:42 Q. And if you're contacted about
09:54:44 a death in a long-term care home, is that
09:54:47 process any different?
09:54:48 A. No.

09:54:49 Q. And my understanding is that
09:54:54 there's certain types of cases that are much
09:54:58 more likely to require a coroners
09:55:01 investigation. And in that, I'm referring to
09:55:05 homicides or suicides, cases of that nature.
09:55:08 A. Yes, they require.
09:55:10 Q. It is required in those
09:55:11 instances?
09:55:11 A. Homicide, suicide, accident.
09:55:14 Q. My understanding is that
09:55:15 there's another category of cases, which is
09:55:18 called in the coroners materials, the apparent
09:55:22 natural death?
09:55:23 A. Yes.
09:55:24 Q. And in those cases, you have
09:55:25 to exercise your judgment as to whether or not
09:55:28 a coroners investigation should be commenced?
09:55:33 A. Yes.
09:55:34 Q. So could you help us
09:55:37 understand, how do you determine whether or not
09:55:40 an apparent natural death should be accepted as
09:55:43 a coroners case?
09:55:44 A. Well, there's a few things
09:55:47 that -- like, if it's a child under CA -- like,
09:55:52 there's a few other very -- some specific
09:55:54 things like a child under CAS care, a group
09:55:59 home, a death in a group home, mental health
09:56:03 institutions, facilities, things like that.
09:56:11 So those are part of the
09:56:12 criteria. If there's any concerns of care from
09:56:14 either the family or the caregivers. And then
09:56:23 it would be whether -- whether the death was

reasonably foreseeable or no.

Q. So those categories you just described, I'm understanding you say those are instances where you would commence --

A. Yes.

Q. -- a death investigation?

A. Yeah.

Q. But if those circumstances aren't present, based on the information you've received, and a death is reported to you which may be apparently natural, can you describe how you determine whether or not a coroners investigation is commenced?

A. A lot of it's information gathering. And then, like I say, based on -- based on the circumstances, a person's, like, past medical history, medications, the circumstances right around the time of death, then if there's a -- if it was reasonably foreseeable and that I could determine, you know, a cause of death on the balance of probabilities, then -- and then I may not investigate. Once again, it's hard to say a hard and fast because every death is different.

Q. And I appreciate that. So perhaps you could assist us with an example. Is there a circumstance you could describe where an apparently natural death would not require, in your view, a coroners investigation as opposed to another where it would?

A. So I guess -- so if there -- so if there's a 50-year-old gentleman who just

suddenly collapsed, I would -- especially if there's no -- he was a reported healthy gentleman, had no medications, nothing like that, I would investigate that.

However, for that same 50-year-old gentleman had a history of lifelong smoking, blood pressure, diabetes, has had two heart -- prior heart attacks already and, on that day, was reported to have some chest pain and shortness of breath, I may decline that case unless there's other extenuating circumstances, because you can -- he has a history of heart disease. He's had that chest pain leading up to his collapse.

So even though they both collapsed and was sudden, you could, on the balance of probabilities, say that second gentleman's death was reasonably foreseeable given his past medical history and the circumstances at that time.

Q. And you use the word "sudden." We've actually heard a number of people provide evidence thus far about the notion of a death being sudden and unexpected.

A. Mm-hm.

Q. I understand that's a basis upon which a coroners investigation may be commenced?

A. Yes.

Q. And can you explain what to you, as an investigating coroner, the term "sudden and unexpected" means?

09:59:27 1 A. Basically that -- sudden sort
09:59:32 2 of refers to the timing to me, and then that
09:59:36 3 unexpected, it goes back to that example I just
09:59:40 4 gave. Is it reasonably foreseeable from the
09:59:45 5 person's medical history and the circumstances
09:59:48 6 that the death would occur.
09:59:50 7 Q. In your view, does that term,
09:59:54 8 "sudden and unexpected," have meaning in the
09:59:57 9 context of a long-term care home resident?
10:00:00 10 A. Yes.
10:00:06 11 MS. ROBINSON: If you could
10:00:07 12 please, Ms. Clewley, turn up
10:00:11 13 Document 72836. And that's at
10:00:17 14 Tab 23 of the document brief.
10:00:17 15 BY MS. ROBINSON:
10:00:28 16 Q. Dr. Urbantke, is this a
10:00:30 17 document that you recognize?
10:00:31 18 A. Yes.
10:00:32 19 Q. It's the Case Selection Data
10:00:35 20 Form, which, again, we've heard about already
10:00:37 21 in the inquiry. Can you explain if this is a
10:00:40 22 form that you utilize in your practice?
10:00:45 23 A. I have used it, yes.
10:00:46 24 Q. You have used it. Is it one
10:00:47 25 that you use presently?
10:00:48 26 A. Occasionally.
10:00:49 27 Q. And can you describe how it's
10:00:51 28 used in your practice?
10:00:52 29 A. I would fill it out if I've
10:00:54 30 declined a death, to fax in to the -- or email
10:00:59 31 in to the regional coroners office.
10:01:01 32 Q. And is that something that

10:01:03 you continue to do?
10:01:03 A. At this point in time, not on
10:01:06 a consistent basis. At one point, I did.
10:01:11 Q. And why was there a change in
10:01:14 your practice?
10:01:14 A. My understanding was this
10:01:15 would help track numbers of declined cases, and
10:01:19 then when provincial dispatch came in, they had
10:01:23 the record of what -- who was declined in
10:01:27 numbers. So I haven't been as consistent at
10:01:31 this point.
10:01:31 Q. Did you find this to be a
10:01:35 helpful form to utilize when you were assessing
10:01:39 whether or not to accept a case for a death
10:01:42 investigation?
10:01:42 A. I wouldn't -- I wouldn't
10:01:46 necessarily use it in my -- like, a
10:01:49 decision-making tool. I would basically go
10:01:54 through the steps. But would I have it in
10:01:56 front of me? No, not necessarily.
10:01:58 Q. So you would make that
10:02:00 decision, and then when you came to the
10:02:01 decision that it was not a coroners case,
10:02:03 that's when you would turn and complete the
10:02:06 form; is that accurate?
10:02:07 A. Yes.
10:02:07 Q. And just to confirm, you
10:02:11 described the information you'd have in front
10:02:13 of you when making an assessment of a case.
10:02:17 You described calling the contact person to get
10:02:19 more information from them?
10:02:20 A. Yes.

10:02:21 Q. Were there any other sources
10:02:23 of information that you would have in assessing
10:02:25 whether or not a case was properly a coroners
10:02:27 investigation?
10:02:27 A. I could -- so I could speak
10:02:32 to other people and sort of -- for example, if
10:02:40 a death occurred at home, usually it's a police
10:02:43 officer that would call me.
10:02:46 I would ask to speak to the
10:02:48 family on the phone. I could call family
10:02:52 doctors. I could call other caregivers, and I
10:02:55 could look at medical records.
10:02:57 Q. And in your practice, do you
10:02:59 take any or some of those steps?
10:03:00 A. It varies what steps I do,
10:03:05 but yes.
10:03:07 Q. We've heard of an
10:03:11 Institutional Patient Death Record which is
10:03:14 submitted in the context of a death in a
10:03:16 long-term care home.
10:03:16 A. Yes.
10:03:17 Q. Are you familiar with that
10:03:18 document?
10:03:18 A. Yes.
10:03:18 Q. Would you have that document
10:03:20 available to you when making an assessment as
10:03:22 to whether or not to accept a case for death
10:03:24 investigation?
10:03:24 A. No.
10:03:24 Q. So if, based on the
10:03:32 information you've been provided, you determine
10:03:34 that a case is not going to proceed for a death

10:03:38 1 investigation, what do you do?
10:03:41 2 A. I usually would talk to the
10:03:46 3 person I'm speaking to about my reasoning, said
10:03:49 4 that the document that they call me, and I've
10:03:53 5 spoken to them, and then I would call dispatch
10:03:55 6 and say I've declined the case.
10:03:57 7 Q. And when you tell dispatch
10:04:00 8 that you've declined the case, what do you tell
10:04:02 9 them?
10:04:02 10 A. I tell them I've declined. I
10:04:08 11 may tell them the cause of death, but
10:04:13 12 generally, that's -- it's just basic
10:04:15 13 information.
10:04:15 14 Q. Will you provide dispatch
10:04:17 15 your rationale for why you declined a case?
10:04:24 16 A. No.
10:04:24 17 Q. Will you report the fact that
10:04:26 18 you declined a case to anyone other than
10:04:31 19 dispatch?
10:04:31 20 A. If I fill out the Case
10:04:33 21 Selection Form, it would go to the regional
10:04:36 22 supervising coroner.
10:04:36 23 Q. Can you estimate at present
10:04:36 24 how regularly you are completing the Case
10:04:41 25 Selection Data Form and submitting it to your
10:04:44 26 regional supervising coroner?
10:04:44 27 A. It will probably be at
10:04:46 28 present infrequently, because as I mentioned,
10:04:49 29 I -- my understanding was to track numbers,
10:04:52 30 so...
10:04:52 31 Q. If you've made that decision
10:04:54 32 to decline a case --

10:04:56 A. Yes.
10:04:57 Q. -- what documentation, if
10:04:59 any, do you maintain about that decision?
10:05:02 A. I have my, like, handwritten
10:05:03 notes that I would be making as I'm speaking
10:05:07 with people, and then I retain those notes.
10:05:10 Q. And how do you retain them?
10:05:12 A. I keep them in my coroners
10:05:16 files.
10:05:16 Q. For how long do you retain
10:05:18 them?
10:05:18 A. I have all of them back to
10:05:20 when I began being a coroner.
10:05:22 Q. And one more question about
10:05:24 the Case Selection Data Form. You indicated
10:05:26 you're submitting it infrequently at this
10:05:28 stage?
10:05:29 A. Mm-hm.
10:05:29 Q. Have you ever received a call
10:05:31 from the London office asking you to submit
10:05:34 Case Selection Data Forms?
10:05:35 A. Not that I recall.
10:05:37 Q. I'm going to turn now to ask
10:05:44 you about the opposite, when you've accepted a
10:05:49 case for death investigation. I'm going to ask
10:05:52 you to walk us through your process in the
10:05:54 context of a death in a long-term care home.
10:05:54 A. Okay.
10:05:57 Q. But before I do, can you
10:05:59 identify when the last time it was that you
10:06:03 completed a death investigation in a long-term
10:06:07 care home?

10:06:07 A. I can't recall.
10:06:08 Q. Do you have a sense of if
10:06:10 that was months or years ago?
10:06:12 A. I'm going to say months to a
10:06:16 year at least.
10:06:16 Q. And we've heard evidence that
10:06:21 in 2013, the Office of the Chief Coroner
10:06:24 changed its policy and no longer required
10:06:28 mandatory investigations of every tenth death
10:06:31 in a long-term care home.
10:06:32 A. Okay.
10:06:32 Q. That was called the threshold
10:06:34 death investigation?
10:06:35 A. Yes.
10:06:35 Q. In your view, as a local
10:06:38 coroner, did you see value in conducting
10:06:47 threshold death investigations prior to 2013?
10:06:49 A. It was variable. Sometimes I
10:06:52 did identify missed coroners cases. Sometimes
10:06:56 I didn't, so...
10:06:59 Q. And do you recall if you had
10:07:02 any views in 2013 when that policy change came
10:07:06 into place about the change?
10:07:08 A. I don't recall.
10:07:08 Q. So you're not presently
10:07:14 conducting threshold death investigations?
10:07:16 A. No.
10:07:16 Q. But when you were, would that
10:07:19 death investigation in the context of a
10:07:24 threshold case vary in any way from any other
10:07:27 death investigation conducted in a long-term
10:07:29 care home?

10:07:29 A. No.
10:07:29 Q. Your process for
10:07:31 investigation was the same?
10:07:31 A. Yes.
10:07:32 Q. So in that sense, then, I
10:07:39 would appreciate if you could walk us through
10:07:41 your process for a death investigation in a
10:07:43 long-term care home.
10:07:43 A. So I would usually speak to
10:07:48 someone over the phone, gather information at
10:07:50 that time, would attend the long-term care
10:07:55 facility. Usually they've told me what care
10:07:57 station to go to, and I'd seek out hopefully
10:08:00 the person that talked to me at that point in
10:08:03 time or a staff member that could assist me.
10:08:05 Q. And just pausing there, when
10:08:07 you've accepted a case and before you attended
10:08:09 the home, do you report to anyone that you've
10:08:12 accepted the case for death investigation?
10:08:13 A. No.
10:08:14 Q. Okay. Is there any
10:08:18 requirement for how timely your attendance at
10:08:21 the long-term care home is?
10:08:22 A. I would say it's as soon as
10:08:25 possible, but not a hard-and-fast rule that I'm
10:08:32 aware of.
10:08:32 Q. And then you indicate you
10:08:36 would attend at the home. Can you explain what
10:08:39 your next investigative steps would be?
10:08:41 A. As I said, usually I would
10:08:42 try to find the area of the home where the
10:08:45 deceased is. In general, I would say I go

10:08:49 1 examine the -- I go immediately to the room and
10:08:50 2 examine the body usually because there's a
10:08:53 3 staff person who is there to lead me to the
10:08:57 4 room and then assist me if I need help rolling
10:09:02 5 and examining the -- moving the deceased, to
10:09:07 6 help me do that.
10:09:11 7 And then after they -- if --
10:09:11 8 sometimes family will be there. If family are
10:09:14 9 in the room, I often -- I will invite them to
10:09:19 10 stay. I will explain what my role is and what
10:09:22 11 I'm about to do. I will invite them to stay
10:09:27 12 but leave the choice to them. Some people are
10:09:32 13 comfortable; some aren't.
10:09:34 14 And then after my examination, I
10:09:35 15 usually will go back to the care station or the
10:09:38 16 nursing station to examine the medical records.
10:09:40 17 Q. And stopping there, could you
10:09:42 18 explain what sort of examination you're doing
10:09:46 19 in that context?
10:09:47 20 A. So just walking into the room
10:09:53 21 or the area where the -- generally in the
10:09:57 22 long-term care facilities, they'd be in a room.
10:10:00 23 Just a general sense of the room. And then
10:10:05 24 once again, a general sense of the body, how
10:10:08 25 the body -- where the body is, how the body is
10:10:11 26 positioned, and basically a head-to-toe
10:10:13 27 examination.
10:10:13 28 Q. And you indicated once you
10:10:18 29 complete that examination, you proceed to the
10:10:22 30 nursing station?
10:10:23 31 A. In general.
10:10:23 32 Q. And you review the medical

10:10:24 records at that time?
10:10:25 A. Yes.
10:10:25 Q. What types of medical records
10:10:29 are you reviewing?
10:10:30 A. In general, it's -- they have
10:10:36 a chart. Originally, it was all paper. Last
10:10:41 time I went in it was a bit -- some are more
10:10:44 mixed now between electronic records and paper
10:10:47 charts.
10:10:47 So I would review both --
10:10:52 both -- so basically I would go through the
10:10:55 chart and looking at different information.
10:10:58 Q. Are there particular records
10:11:00 that you would always review in the context of
10:11:02 a death investigation?
10:11:02 A. You remain an --
10:11:05 Q. Medical chart.
10:11:06 A. For the specific person?
10:11:08 Q. Yes.
10:11:09 A. Usually there's, like, a --
10:11:12 I'm going to call it a demographic sheet, so
10:11:16 it -- most of them have a picture of the
10:11:19 deceased, the name, you know, family contact or
10:11:23 power of attorney information, when they were
10:11:25 admitted to the long-term care facility, a list
10:11:31 of their sort of past diagnoses.
10:11:32 So I would usually start with
10:11:34 there just to sort of get an overview. And
10:11:36 then I would start going through the charts,
10:11:41 medical -- like, medication, what medications
10:11:45 they were on, history and physicals or any
10:11:49 doctors' notes and then also the nursing

10:11:51 Progress Notes. Yeah, basically I flip through
10:11:59 the chart.
10:12:00 Q. And how far back in the time
10:12:03 do you go in your review in terms of the
10:12:05 medical records?
10:12:05 A. I would say it depends on the
10:12:07 circumstances.
10:12:09 Q. And what informs that
10:12:12 decision?
10:12:12 A. Whether -- so whether it was
10:12:16 an acute event that happened, and then -- it's
10:12:21 really hard to say because it sort of depends,
10:12:25 but it usually -- I would go back to at least
10:12:27 that event and then a bit farther. And I can't
10:12:30 tell you 100 percent how far.
10:12:32 Q. Beyond the either paper or
10:12:36 electronic or both chart that you're reviewing,
10:12:39 are there any other records at a long-term care
10:12:42 home that you would review?
10:12:43 A. There's what I would call the
10:12:46 death registry. I would review that.
10:12:49 Q. I'll ask you a few questions
10:12:50 about that in a moment.
10:12:53 A. Okay.
10:12:54 Q. Besides the death registry,
10:12:58 any other types of records or documents you
10:12:59 would typically review?
10:12:59 A. Not 100 percent of the time.
10:13:02 Depending on the circumstances. Incident
10:13:04 reports, things like that.
10:13:05 Q. And an Incident Report, in
10:13:07 what circumstance would you likely review that?

10:13:09 A. Maybe a fall.
10:13:10 Q. If there was an Incident
10:13:12 Report related to that fall?
10:13:13 A. Yes.
10:13:13 Q. In the course of your
10:13:16 investigation, are you making any notes or
10:13:19 documentation?
10:13:20 A. Yes. I make handwritten
10:13:22 notes as I go along.
10:13:23 Q. Is there a particular
10:13:25 document or form that you use?
10:13:27 A. In general, there's -- there
10:13:30 is a form called a Coroners Investigation
10:13:34 Worksheet. In general, I'll use those,
10:13:37 although every now and then, I forget to
10:13:39 photocopy and replenish my stack. So if I've
10:13:43 run out, I'll use any piece of paper.
10:13:46 Q. And if you could turn to
10:13:48 Tab 6 of your document brief, and that's
10:13:51 Document 72832. Is this the Coroners
10:14:08 Investigation Worksheet you were referencing?
10:14:09 A. Yes.
10:14:09 Q. Do you recall how you came
10:14:11 into possession of this document?
10:14:12 A. I've used -- I must have got
10:14:17 it from my original course or from -- I've used
10:14:22 it as long as I can remember.
10:14:24 Q. And at what point in time
10:14:26 during your investigation are you documenting
10:14:28 on the Coroners Investigation Worksheet or the
10:14:30 piece of paper as you described?
10:14:32 A. Like, as I'm going through

10:14:36 medical records, I'll be writing, like,
10:14:39 concurrently.
10:14:40 Q. Is the Institutional Patient
10:14:42 Death Record a document that you would review?
10:14:43 A. It's often sort of stacked up
10:14:50 on the chart with all the papers related to the
10:14:53 deceased, so it's often there that I would look
10:14:56 at it.
10:14:56 Q. So you've described examining
10:14:58 the body and reviewing records. Is there
10:15:01 anyone that you would speak to at this stage of
10:15:04 your investigation?
10:15:04 A. In -- I've often spoken to
10:15:10 someone at the -- like, a staff member because
10:15:14 they've led me to the room, so I would be
10:15:17 speaking to them about the deceased as we're
10:15:19 walking to the room and asking them questions.
10:15:21 And then if family are present
10:15:24 there at the time, I would -- I would talk to
10:15:27 them. And then I -- if the family weren't, it
10:15:33 is my practice to call them. It might not
10:15:36 be -- if it's 4 o'clock in the morning, I might
10:15:39 not call them at that instant, but generally
10:15:42 within the day.
10:15:43 Q. And you said it's your
10:15:45 practice to contact the family?
10:15:47 A. Yeah.
10:15:48 Q. Why is that?
10:15:49 A. Because they're the family.
10:15:50 They're the next of kin, so to see if they have
10:15:55 any concerns or anything.
10:15:56 Q. How do you identify which

10:15:57 1 family member to speak to?
10:15:58 2 A. Usually in the -- in
10:16:03 3 long-term care facilities, as I said, there's
10:16:07 4 that demographic sheet that will list -- often
10:16:10 5 there's two or three, I think, like, power of
10:16:15 6 attorney or first contact, second contact,
10:16:18 7 things like that.
10:16:18 8 Q. Do you have a general
10:16:19 9 practice in terms of what you say or ask of a
10:16:22 10 family member in this context?
10:16:24 11 A. I would express my
10:16:28 12 condolences and basically ask maybe some
10:16:32 13 general questions and then ask them if there
10:16:39 14 was any concerns.
10:16:40 15 Q. What do you do if you can't
10:16:43 16 reach a family member?
10:16:43 17 A. I would try again if I --
10:16:51 18 probably -- I can't say if I -- I can't say how
10:16:55 19 many times I try, if I'm totally unsuccessful,
10:17:00 20 but I generally try my best.
10:17:02 21 Q. And we've heard evidence
10:17:08 22 about the coroners office having certain
10:17:10 23 booklets or pamphlets that are available to
10:17:13 24 family members.
10:17:13 25 A. Yes.
10:17:14 26 Q. Are you familiar with those
10:17:15 27 documents?
10:17:15 28 A. Yes.
10:17:15 29 Q. Do you utilize them in your
10:17:17 30 practice?
10:17:17 31 A. Yes.
10:17:17 32 Q. And would you provide your

10:17:22 contact information to a family member?
10:17:23 A. Yes. So if -- if they were
10:17:26 physically present -- I have a card. I would
10:17:30 provide that and generally the booklet. I
10:17:32 often staple them together because cards are
10:17:35 easily lost. And then if they're -- if I
10:17:40 contact them by telephone, I would give them my
10:17:42 name and number.
10:17:43 Q. Is it the case that you will,
10:17:45 on occasion, speak to a family member after
10:17:47 that first day at the long-term care home?
10:17:49 A. Yeah. I -- so you mean that
10:17:54 I can't get ahold of them or -- I'm not sure.
10:17:58 Q. So in the context where
10:18:00 you've met them and you've provided your
10:18:02 contact information to them, do you find that
10:18:04 family members will reach out and contact you
10:18:07 in the future?
10:18:08 A. I'll say it's infrequently.
10:18:12 I do say my -- I usually say I know it's --
10:18:15 because it's a confusing and very busy time, I
10:18:20 usually leave it open that if you have any
10:18:23 concerns or even in a couple of weeks you have
10:18:25 a question that I can try to answer, feel free.
10:18:29 I can't say I get many calls.
10:18:34 Q. If you do receive a call of
10:18:35 that nature, what is your practice in terms of
10:18:38 documentation?
10:18:38 A. I would document it usually
10:18:41 on the Coroners Worksheet, like, my -- that's
10:18:46 my sort of living document, I guess that would
10:18:48 be called. So if I filled that up or on the

10:18:54 back or an extra sheet, which I staple
10:18:57 together.
10:18:57 Q. In terms of other persons you
10:18:57 may speak to in the course of your
10:19:00 investigation, you described the individual at
10:19:03 the care home who would take you to the room?
10:19:04 A. Mm-hm.
10:19:04 Q. Do you have a practice in
10:19:06 terms of speaking with any other health
10:19:07 practitioners, in particular?
10:19:08 A. I may speak to the family
10:19:13 physician or the physician in charge of their
10:19:16 care. I can't say it's 100 percent of the
10:19:19 time.
10:19:19 Q. And why would you make that
10:19:21 inquiry?
10:19:21 A. If I need extra information.
10:19:22 Q. And I understand that there
10:19:28 are certain circumstances in which an autopsy
10:19:31 is required to be ordered?
10:19:34 A. Yes.
10:19:34 Q. Can you give me examples of
10:19:37 when that would be the case?
10:19:38 A. Like, a homicide or an
10:19:40 accident.
10:19:41 Q. In the context of an
10:19:45 apparently natural death, when you're
10:19:48 conducting an investigation, how do you make a
10:19:50 determination about whether or not an autopsy
10:19:53 should be ordered?
10:19:53 A. It's -- I -- I guess if I can
10:20:05 reason -- if I'm -- on the balance of

probabilities that if I feel that I can determine the cause of death based on the information that I have, I wouldn't order an autopsy, but if I'm unsure, then I would order an autopsy.

Q. And you've used that expression, "balance of probabilities," a few times.

A. Yeah.

Q. What does that standard or test mean to you?

A. It'd be like a scale. And so if you're tipping one way and it's most likely that, then that would be the balance of probabilities.

Q. Can you describe your process for determining cause of death? How do you come to that conclusion?

A. That's based on all the information I've gathered from the investigation, from records, from conversations, from the physical exam, and then, if necessary, the autopsy.

Q. In your experience as an investigating coroner, how often are autopsies ordered in the context of a death investigation in a long-term care home?

A. Infrequently.

Q. Do you have a sense of why that's the case?

A. I would say that they have -- usually there's a well-documented history, and

10:21:34 you -- because of that history and -- you know,
10:21:37 once again, it depends on the circumstances,
10:21:39 but there's a lot of information usually that
10:21:42 you can put together to make that determination
10:21:45 of cause of death.
10:21:46 Q. Do you recall in your
10:21:48 practice ever ordering an autopsy for a death
10:21:57 investigation in a long-term care home?
10:21:59 A. I can't recall one way or the
10:22:00 other.
10:22:00 Q. You referenced the fact that
10:22:02 in a death investigation in a long-term care
10:22:04 home, you would consult the home's death
10:22:06 registry?
10:22:06 A. Yes.
10:22:06 Q. Do you do that in all
10:22:08 investigations?
10:22:09 A. Yes.
10:22:09 Q. And can you describe your
10:22:11 process for what you do in order to review the
10:22:15 death registry?
10:22:16 A. I would look at the registry,
10:22:22 look at completeness, review -- basically go
10:22:26 through the different columns which are
10:22:28 different categories, like, name -- not
10:22:30 necessarily names, but ages, whether they were
10:22:35 transferred to an acute care hospital and the
10:22:38 causes of death, and then if the -- a coroner
10:22:45 has reviewed something or not.
10:22:46 Q. What are you looking for when
10:22:49 you're undertaking that review?
10:22:50 A. As I said, partially

10:22:52 completeness. If there's been deaths that
10:22:54 should have been reported to a coroner like
10:22:59 a -- if the cause of death is a fractured hip
10:23:02 or a -- like, a brain bleed, that would
10:23:06 indicate most likely it was due to a fall. So
10:23:10 it would be an accidental death.
10:23:12 And it's not ticked off that a
10:23:14 coroner was notified, then -- and that would be
10:23:17 something to identify. And then looking to see
10:23:19 if there's, I'm going to call it, patterns or
10:23:23 anything out of the ordinary.
10:23:26 Q. In that example you described
10:23:30 where you see a case that you think should have
10:23:33 been a coroners case -- or a coroner should
10:23:35 have been notified, rather, what do you do in
10:23:42 that circumstance?
10:23:44 A. I would call -- usually call
10:23:46 provincial dispatch at this stage to say, you
10:23:49 know, I've identified, and probably email the
10:23:53 regional coroner's office.
10:23:56 Q. And why would you be
10:23:59 contacting dispatch or the regional's office?
10:24:02 A. So they have the record of
10:24:03 the investigation, that there needs to be an
10:24:07 investigation.
10:24:08 Q. Are you in a position, then,
10:24:10 to commence that investigation, or would
10:24:12 another coroner need to become involved?
10:24:15 A. In general, it's been myself
10:24:16 that's investigated those ones.
10:24:18 Q. And what would that
10:24:20 investigation consist of?

10:24:22 A. Well, usually the body is not
10:24:25 there anymore, so it's mostly a chart review.
10:24:28 Q. You indicated that one of the
10:24:31 things you're looking for is patterns?
10:24:33 A. Mm-hm.
10:24:34 Q. In that review, are you
10:24:40 looking for an increased rate of death?
10:24:44 A. It could be, but, once again,
10:24:47 it's very -- just, like, it's very variable how
10:24:50 many calls I get and not an increased rate --
10:24:54 it depends.
10:24:54 Q. That's what I'm trying to
10:24:56 understand. When you say you're looking for
10:24:57 patterns -- did you use the word "clusters"?
10:25:00 Am I recalling correctly? You're looking for
10:25:03 patterns?
10:25:03 A. Yeah.
10:25:04 Q. How do you determine that?
10:25:05 A. Once again, it's just looking
10:25:09 through time -- timing -- mostly the timing and
10:25:14 is there any, like, groupings or something like
10:25:17 that.
10:25:17 Q. So setting aside the
10:25:20 instances where you may have found a case that
10:25:22 you think should have been a coroners case and
10:25:25 you take additional steps, in a more typical
10:25:30 review, if I can call it that, is your review
10:25:32 limited to simply looking at that document, the
10:25:35 death registry?
10:25:36 A. No. I can ask for charts
10:25:38 from that, like, of the previous deceased.
10:25:41 Q. Is that your practice, to

review the charts of the prior deceased?

A. Not consistent. Like, if there's something that I'm not sure of, then I may ask for it. I wouldn't ask for, like, all -- say if it was a threshold case, I wouldn't ask for all ten charts, no.

Q. Are you aware, is that an expectation that a coroner would be looking at the medical charts during the death -- review of the death registry?

A. I'm not aware.

Q. And I believe you indicated just then that in a threshold case, you'd be looking back at the prior nine deaths; is that correct?

A. Yes.

Q. Now that threshold deaths aren't being investigated -- and it could be longer than every tenth death that a coroner is in a long-term care home doing a death investigation -- how far back would you look in the death registry if you're undertaking that review?

A. I would probably go back to the last time there was a coroner noting.

Q. When you're undertaking that review of the death registry, do you have a belief as to whether or not that review would be helpful in detecting harm of a resident by a caregiver?

A. It's hard to say. It would be difficult.

10:27:20 Q. And I would like you to turn
10:27:25 to Tab 19, please, and to the final page at
10:27:28 that tab, which is Document 71977.
10:27:39 Just to give an example of where
10:27:41 it appears that you undertook this threshold --
10:27:45 in the context of a threshold death
10:27:50 investigation, a review of the death registry.
10:27:51 And for that, I'm referencing
10:27:53 number 10 on the left side, patient MP. And I
10:27:53 see your name is written at the far right-hand
10:28:01 side of the document. What does that tell you?
10:28:02 A. That I was in to review that
10:28:04 death.
10:28:04 Q. And based on the practice
10:28:07 that you've described, do you believe or do you
10:28:11 know if you would have reviewed the ten prior
10:28:13 deaths in the registry?
10:28:15 A. That would be my practice.
10:28:16 Q. So you would have reviewed,
10:28:18 then, you believe, the death -- the ninth
10:28:22 death, Helen Young?
10:28:24 A. I would have saw it. It was
10:28:26 right above the one I investigated.
10:28:28 Q. And what does the document
10:28:30 reveal about her age?
10:28:31 A. She's 90 years old.
10:28:33 Q. And her cause of death
10:28:34 included on the document?
10:28:35 A. Old age, debility, atrial
10:28:39 fibrillation.
10:28:40 Q. And based on that information
10:28:42 contained -- firstly, do you have any

10:28:44 recollection of conducting this particular
10:28:47 threshold death investigation?
10:28:48 A. No.
10:28:49 Q. Based on the information
10:28:50 that's contained in the registry, do you
10:28:52 believe that you would have taken any further
10:28:54 steps as you've described potentially reviewing
10:28:57 the medical records?
10:28:57 A. I can't recall.
10:28:58 Q. Do you believe that you would
10:29:00 have based on the age, date of death, and cause
10:29:05 of death listed?
10:29:06 A. Most likely not, but I'm
10:29:10 not -- I can't recall.
10:29:11 Q. And if you note at the top of
10:29:13 the page, there's the information, average
10:29:16 number of deaths per month, average number of
10:29:19 transfers per month, and it's not completed.
10:29:22 Is that something that you
10:29:23 review in part of your review of the death
10:29:25 registry?
10:29:25 A. No. I don't think I've ever
10:29:29 seen that completed in any long-term facility.
10:29:32 Q. Other than the process you've
10:29:39 described, are there any other steps that you
10:29:41 would take in a typical death investigation in
10:29:43 a long-term care home?
10:29:44 A. Not in a typical one that I
10:29:51 can think of at this point.
10:29:52 Q. And then I understand that an
10:29:54 investigation is completed by the completion of
10:29:57 a Form 3, a Coroners Investigation Statement?

10:30:00 A. Correct.
10:30:01 Q. And when is that document
10:30:03 completed?
10:30:03 A. When I have all the final --
10:30:09 you can submit a preliminary and then a final.
10:30:12 So, like, you can -- so the final one, it
10:30:17 depends because the final wouldn't go in
10:30:21 until -- like, if I did order a postmortem
10:30:23 examination, I wouldn't submit a final until I
10:30:26 had the result -- all the results back. But
10:30:30 you can submit preliminary -- a preliminary
10:30:33 report prior to that.
10:30:34 Q. And what is your practice in
10:30:36 terms of -- relative to when you start the
10:30:40 death investigation, when do you, yourself,
10:30:43 complete the documentation of a Form 3?
10:30:45 A. Generally, I would input it
10:30:48 within a week to two weeks.
10:30:50 Q. In the ordinary course, if
10:30:54 you conduct a death investigation, would you,
10:30:57 as the coroner, complete the Medical
10:31:00 Certificate of Death?
10:31:00 A. In the ordinary course.
10:31:02 Q. Would you necessarily
10:31:04 complete the Medical Certificate of Death?
10:31:06 A. Sometimes another physician
10:31:10 or a nurse practitioner has completed it. If I
10:31:15 don't agree with it, I will complete a new one,
10:31:19 but if I agree with it, I would probably just
10:31:24 leave the original.
10:31:25 Q. I'd appreciate if you would
10:31:31 help us to understand your mind-set as an

10:31:34 1 investigating coroner doing a death
10:31:36 2 investigation in a long-term care home.
10:31:39 3 Now, before Ms. Wettlaufer's
10:31:41 4 offences became known, when you were conducting
10:31:45 5 a death investigation in that context, were you
10:31:49 6 considering the possibility of harm or
10:31:52 7 intentional harm by a caregiver against a
10:31:55 8 resident?
10:31:55 9 A. You always have to keep an
10:32:01 10 open mind. I would -- when I'm thinking of
10:32:06 11 intentional harm prior to this, I would be
10:32:10 12 thinking more, like, along the -- like,
10:32:13 13 physical harm and neglect.
10:32:19 14 Q. And I understand your job as
10:32:22 15 an investigating coroner is to determine both
10:32:24 16 the cause of death and the manner of death?
10:32:28 17 A. Yes.
10:32:28 18 Q. And that there are five
10:32:31 19 possible manners of death that can be assigned
10:32:33 20 to a case?
10:32:34 21 A. Correct.
10:32:34 22 Q. What are those five manners
10:32:36 23 of death?
10:32:37 24 A. Natural, accident, suicide,
10:32:40 25 homicide, and undetermined.
10:32:40 26 Q. And prior to Ms. Wettlaufer's
10:32:43 27 offences becoming known, when you were
10:32:45 28 conducting a death investigation in a long-term
10:32:47 29 care home, would you be considering any or all
10:32:51 30 of those potential manners of death?
10:32:53 31 A. Yeah, any and all.
10:32:56 32 Q. I'm going to turn now to ask

10:33:02 1 you some questions about a death investigation
10:33:03 2 that you, yourself, conducted. You were the
10:33:07 3 coroner who conducted the death investigation
10:33:10 4 pertaining to Mr. Wayne Hedges; is that
10:33:14 5 correct?
10:33:14 6 A. I don't have any
10:33:15 7 recollection, but the records indicate.
10:33:17 8 Q. So do you have any
10:33:18 9 recollection at all of conducting that death
10:33:24 10 investigation?
10:33:25 11 A. No. It's just based on the
10:33:26 12 records.
10:33:26 13 Q. But I understand that you
10:33:28 14 have presently reviewed the records?
10:33:30 15 A. Correct.
10:33:30 16 Q. And you're able to give
10:33:31 17 evidence based on your review of the records
10:33:33 18 and your general practice?
10:33:34 19 A. Yes.
10:33:35 20 Q. If you could turn to Tab 14
10:33:38 21 of your document brief, please, and that's
10:33:42 22 Document 64920, page 6. And what is this
10:34:01 23 document?
10:34:01 24 A. It's a warrant to take
10:34:03 25 possession of the body.
10:34:04 26 Q. And it looks like that's your
10:34:10 27 signature under the --
10:34:10 28 A. Yes.
10:34:10 29 Q. -- coroner line?
10:34:12 30 When would you have completed
10:34:15 31 this document?
10:34:16 32 A. At the beginning of my

10:34:17 investigation.
10:34:17 Q. And once completed, what do
10:34:20 you do with this document?
10:34:21 A. I retain it with the file,
10:34:22 and then once we submit our Form 3, a list --
10:34:28 we would -- there's a list of them print out,
10:34:30 and then I would fax the list and the Form 3s
10:34:38 into the regional supervising office or email
10:34:43 them. I don't know.
10:34:44 Q. And what's your understanding
10:34:45 of the purpose of this document?
10:34:46 A. It gives me the authority to
10:34:47 do the investigation.
10:34:48 Q. If you could turn next to
10:34:52 Tab 15, please. That's Document 64920, page 5.
10:35:01 A. Yeah.
10:35:01 Q. We'll just wait for the
10:35:03 document on the screen.
10:35:04 A. Oh, sorry.
10:35:05 Q. Do you recognize this
10:35:14 document?
10:35:14 A. I've -- yeah, I've seen it.
10:35:19 Q. The Case Notification Form?
10:35:21 A. Yes.
10:35:22 Q. And do you use this Case
10:35:27 Notification Form in your practice?
10:35:27 A. No.
10:35:28 Q. Did you ever use it as part
10:35:29 of your practice?
10:35:30 A. Not that I recall.
10:35:31 Q. And do you have any knowledge
10:35:32 of who, in fact, completed this form?

10:35:33 A. I don't know.
10:35:34 Q. Would this be contained in
10:35:38 your records pertaining to Mr. Hedges' death
10:35:41 investigation?
10:35:41 A. It wasn't.
10:35:42 Q. So because you don't have a
10:35:47 recollection of this death investigation, I'm
10:35:49 going to take you to the Caressant Care
10:35:51 Progress Notes to understand the information
10:35:54 they can provide us.
10:35:56 A. Okay.
10:35:56 Q. That's Tab 18 of the document
10:36:00 brief behind Tab A, and that's page -- pardon
10:36:04 me, Document 783, page 1.
10:36:23 A. 7803?
10:36:27 Q. Yes. Thank you. If you
10:36:33 could scroll, please, to the entry on
10:36:35 January 24th, 2009, at 1:30. It's on page 1.
10:36:43 Yes. Thank you. There.
10:36:45 So, Dr. Urbantke, if you could
10:36:48 look at that entry at 1:30 on January 24th. At
10:36:54 the very end, it indicates: [AS READ]
10:36:56 "Respiration and pulse ceased at
10:36:59 01:05 hours. Call placed to
10:37:02 coroners answering service as
10:37:04 this is a threshold case as well
10:37:05 as the third death within 24
10:37:06 hours. Awaiting a return call
10:37:08 at this time."
10:37:09 And then the entry above at 1:56 in the morning
10:37:16 indicates: [AS READ]
10:37:16 "Call received from

10:37:17 1 Dr. Urbantke, coroner on call."
10:37:19 2 And to confirm, would you have seen this
10:37:22 3 document in your ordinary course?
10:37:23 4 A. No.
10:37:24 5 Q. And the note indicates that
10:37:28 6 you stated you will not be able to be in to
10:37:32 7 pronounce the death until morning at the
10:37:34 8 earliest but likely not until early afternoon.
10:37:34 9 [AS READ]
10:37:38 10 "She states she will require
10:37:40 11 Wayne's chart and the death
10:37:40 12 register. She requested I call
10:37:41 13 the physician on call and have
10:37:41 14 them pronounce the death
10:37:43 15 instead. Dr. Miettinen informed
10:37:43 16 and will be in in the morning.
10:37:46 17 Wayne's mother informed."
10:37:46 18 Do you know who Dr. Miettinen is?
10:37:46 19 A. He's a family doctor in
10:37:55 20 Woodstock.
10:37:55 21 Q. And do you have any
10:37:55 22 information to contradict or additional
10:37:57 23 information in respect of this note at 1:56 in
10:37:59 24 the morning?
10:37:59 25 A. I don't.
10:38:01 26 Q. And just further with the
10:38:05 27 timeline, there's an entry at 8:15: [AS READ]
10:38:08 28 "Dr. Miettinen in and
10:38:10 29 pronounced."
10:38:12 30 Just at the top of the page there. And if you
10:38:12 31 would scroll up slightly, please, Ms. Clewley.
10:38:12 32 [AS READ]

10:38:17 1 "At 9:20, body released to the
10:38:20 2 funeral home."
10:38:23 3 Again, do you have any additional or other
10:38:25 4 information to contradict the information
10:38:26 5 contained in the Progress Note?
10:38:28 6 A. No.
10:38:29 7 Q. And you've described your
10:38:31 8 process, your general process for conducting a
10:38:34 9 death investigation in a long-term care home.
10:38:36 10 Do you have any information or belief to
10:38:38 11 suggest that this process was any different in
10:38:43 12 the context of the death investigation
10:38:44 13 pertaining to Mr. Hedges?
10:38:45 14 A. No.
10:38:45 15 Q. So I'll ask you, then, to
10:38:51 16 turn next to Tab 16 of the document brief,
10:38:56 17 which is Document 69423, page 3. And can you
10:39:14 18 identify this document, please?
10:39:15 19 A. That's my handwritten note.
10:39:17 20 Q. Your handwritten note?
10:39:19 21 A. For my investigation for
10:39:21 22 Wayne Hedges.
10:39:23 23 MS. ROBINSON: And,
10:39:23 24 Commissioner, this is not yet in
10:39:26 25 evidence, so I propose that it
10:39:28 26 be marked as the next exhibit,
10:39:30 27 please.
10:39:30 28 THE COMMISSIONER: Thank you.
10:39:32 29 Madam Clerk, exhibit --
10:39:35 30 THE REGISTRAR: Exhibit 112.
10:39:37 31 THE COMMISSIONER: Exhibit 112
10:39:38 32 then, handwritten notes. Top,

10:39:40 1 it says January 24th.
10:39:42 2 Document Number 69423, page 3.
10:39:38 3 EXHIBIT NO. 112: Handwritten
10:39:40 4 notes dated January 24th,
10:39:42 5 Document 69423, page 3.
10:39:48 6 BY MS. ROBINSON:
10:39:48 7 Q. And I don't intend to take
10:39:50 8 you through each step of this investigation,
10:39:51 9 but at a high level, I note on the left-hand
10:39:54 10 side, PMH. What does that stand for?
10:39:57 11 A. Past medical history.
10:39:58 12 Q. And where would you have
10:39:59 13 obtained that information from?
10:40:00 14 A. From the medical records.
10:40:03 15 Q. And if you wouldn't mind
10:40:05 16 scrolling down, please. We see meds?
10:40:06 17 A. Yeah.
10:40:07 18 Q. A little further, please.
10:40:07 19 Thank you.
10:40:07 20 Where would you have obtained
10:40:09 21 that information from?
10:40:09 22 A. From the medical record.
10:40:17 23 Usually they have what's called a MAR,
10:40:19 24 Medication Administration Record, so...
10:40:21 25 Q. And the additional
10:40:23 26 information contained in this handwritten note,
10:40:26 27 do you know where you would have obtained that
10:40:28 28 information from?
10:40:28 29 A. I would obtain it at the
10:40:32 30 long-term care facility from the medical
10:40:34 31 records. And I see a note about skin ulcers
10:40:40 32 buttocks, so I assume that's from my physical

10:40:43 examination.
10:40:43 Q. Are you aware of any
10:40:45 reference on this document to contacting any
10:40:50 particular health practitioners or any other
10:40:52 individuals?
10:40:52 A. No specific references.
10:40:56 Q. Is it possible that was part
10:40:57 of your investigation?
10:40:58 A. Yes.
10:40:58 Q. And when would you have
10:41:03 completed this document?
10:41:05 A. As I said, I complete it
10:41:08 concur -- like, while I'm doing the
10:41:09 investigation.
10:41:09 Q. And then if you would turn,
10:41:13 please, to the next tab, 17, which is page 1 of
10:41:17 the same document, Ms. Clewley. And at the
10:41:21 bottom of the page, please, under the
10:41:26 narrative. If you could actually -- between
10:41:28 the two pages is what I'm looking for. If you
10:41:31 could go lower, please.
10:41:34 Your narrative statement
10:41:37 indicates that you concluded that the cause of
10:41:40 death was cerebrovascular accident?
10:41:46 A. Yes.
10:41:46 Q. Can you explain how you would
10:41:48 have made that determination?
10:41:49 A. Well, once again, going back
10:41:51 through the past medical history and then
10:41:53 looking at the circumstances of the death,
10:41:58 it -- just referring to the record, it -- I
10:42:02 noted that it was -- he had a decreased level

10:42:04 of consciousness, not able to swallow, and
10:42:08 unilateral or one-sided drooling, which I felt
10:42:12 would be -- so if someone came to the emergency
10:42:14 department with those symptoms, I would think
10:42:17 it would be a stroke or a cerebrovascular
10:42:22 accident.
10:42:22 Q. You indicated there reference
10:42:24 to your emergency medicine practice?
10:42:26 A. Mm-hm.
10:42:26 Q. Is that a way that you think
10:42:28 about death investigations, comparable to your
10:42:31 other medical practice?
10:42:32 A. It's -- we -- just like we --
10:42:37 if you -- we take a history when you come into
10:42:41 the emergency department. That would be the
10:42:43 same as going through the past medical history,
10:42:45 speaking to others.
10:42:45 And then my physical exam is a
10:42:48 physical exam. And then testing if we need to,
10:42:50 which would basically be the autopsy in a death
10:42:54 investigation.
10:42:54 Q. So can you help us understand
10:42:59 why your determination was in this case, that
10:43:01 the cause of death was cerebrovascular
10:43:07 accident?
10:43:08 A. Well, as I said, he had a
10:43:09 previous history of stroke. And especially
10:43:14 with that one-sided drooling, to me, that
10:43:16 indicated that he's had another stroke.
10:43:19 Q. Just if you could go up on
10:43:22 page 1, please. Thank you. Just there. The
10:43:25 medical cause of death is listed as

10:43:29 cerebrovascular accident?
10:43:29 A. Yeah.
10:43:30 Q. And then there's a
10:43:34 contributing factor listed as diabetes?
10:43:36 A. Mm-hm.
10:43:37 Q. Why would you have listed
10:43:38 that as a contributing factor?
10:43:38 A. Because it's a risk factor
10:43:40 for, like, hardening of or narrowing of the
10:43:42 arteries.
10:43:43 Q. And then if we go back to
10:43:45 where we just were, the next line in the
10:43:48 narrative is: [AS READ]
10:43:49 "Family had no concerns."
10:43:51 Where would you have obtained that information
10:43:52 from?
10:43:52 A. I would have spoke to the
10:43:54 family.
10:43:54 Q. Would you have considered
10:43:58 ordering a postmortem examination or an autopsy
10:44:02 in this case?
10:44:02 A. No.
10:44:02 Q. And why not?
10:44:04 A. Once again, on the balance of
10:44:08 probabilities, especially with that unilateral
10:44:11 drooling -- so if it had been more just global,
10:44:14 it would be a bit more nonspecific, but
10:44:20 especially with that one-sided drooling, I felt
10:44:25 it was a stroke.
10:44:26 Q. And just for the
10:44:27 nonphysicians in the room, is a stroke a
10:44:30 cerebrovascular accident?

10:44:30 A. Yeah.
10:44:31 Q. There were two points of
10:44:34 clarification I hoped you could assist us with
10:44:37 in respect of the death investigation you
10:44:38 conducted pertaining to Mr. Hedges, and the
10:44:42 first arises from the Caressant Progress Note.
10:44:47 It indicated you that you, at
10:44:48 1:56 in the morning, reported that you would
10:44:51 not be able to attend until early afternoon,
10:44:54 maybe the morning.
10:44:57 Do you presently have any
10:45:01 information about what time you arrived at
10:45:03 Caressant Care that date?
10:45:05 A. No.
10:45:05 Q. And we saw from the Progress
10:45:07 Note that the body -- Mr. Hedges' body was
10:45:09 released to the funeral home at 9:20 in the
10:45:13 morning of January 24th.
10:45:14 Is it possible that Mr. Hedges'
10:45:17 body was released to the funeral home before
10:45:18 your arrival at Caressant Care?
10:45:21 A. I can't recall.
10:45:22 Q. Is it possible to complete a
10:45:24 death investigation without viewing and
10:45:27 examining a body?
10:45:29 A. In general, no.
10:45:30 Q. Today, do you believe that in
10:45:34 this instance, you would have seen Mr. Hedges'
10:45:38 body as part of your death investigation?
10:45:41 A. I believe I did. It's my
10:45:43 general practice, but also -- sorry, I forget
10:45:46 what tab my handwritten --

10:45:48 Q. Your handwritten notes are
10:45:51 the prior at Tab 16.
10:45:52 A. 16. I did make note of skin
10:45:56 ulcers buttocks, and that's a physical finding,
10:45:56 so I presume I saw them.
10:45:59 Q. And the second question I had
10:46:01 just as a point of clarification pertained to
10:46:03 the Medical Certificate of Death. And that's
10:46:08 not in the brief before you, but I handed up to
10:46:11 Madam Clerk copies of that document, which is
10:46:14 7608. And this is already in evidence in one
10:46:19 of the Overview Reports. Document 7608.
10:46:44 And if you could scroll down to
10:47:01 the bottom, please. Did you complete the
10:47:04 Medical Certificate of Death pertaining to
10:47:06 Mr. Hedges?
10:47:06 A. No. Dr. Miettinen did.
10:47:08 Q. And why was that the case?
10:47:09 Do you know?
10:47:09 A. I'm not sure why he did it.
10:47:12 Like I said, sometimes physicians or a nurse
10:47:18 practitioner will do it even though it's a
10:47:20 coroners case. As I said, if I agree with it,
10:47:23 I tend not to change it or redo my own. If I
10:47:27 disagree, I will -- would redo it.
10:47:29 Q. Do you believe that -- well,
10:47:33 firstly, would you have reviewed this form in
10:47:35 the course of your death investigation?
10:47:37 A. I would assume it's -- well,
10:47:41 I saw it because I didn't tear it up or revise
10:47:45 it, and I must have agreed with it. Usually
10:47:45 it's -- like, usually there's a stack of papers

10:47:48 with the chart, so I presume it was in there.
10:47:51 Q. And just so that it's clear
10:47:52 to me, if you don't agree with the cause of
10:47:55 death included on a Form 16 or a Medical
10:47:58 Certificate of Death, what is your practice?
10:47:59 A. I would fill out a new one.
10:48:03 Q. And the final area I'd like
10:48:15 to ask you a few questions about pertains to
10:48:15 Ms. Maureen Pickering. And the records
10:48:18 indicate that you had involvement in her care
10:48:20 as an emergency room physician.
10:48:22 Do you have any recollection of
10:48:23 your involvement in Ms. Pickering's care?
10:48:25 A. No.
10:48:25 Q. But I understand that you've
10:48:28 had an opportunity to review those records, and
10:48:30 you can provide evidence based on the contents
10:48:32 of those records; is that fair?
10:48:35 A. Yes.
10:48:35 Q. So from my review of the
10:48:38 records, your first involvement in her care was
10:48:42 her attendance at the emergency department of
10:48:45 the Woodstock Hospital on March 23rd.
10:48:51 Do you have any information to
10:48:52 suggest that you had any prior involvement in
10:48:56 her care?
10:48:56 A. Not that I recall.
10:49:01 Q. So I'll ask you, then, to
10:49:04 turn to Tab 27 of the document brief. That's
10:49:08 page -- or pardon me, Document 65223, page 85.
10:49:25 Dr. Urbantke, based on your
10:49:27 review of this document, can you tell us when

10:49:29 you believe Ms. Pickering would have arrived at
10:49:32 the Woodstock Hospital on March 23rd?
10:49:33 A. Around 11:46 in the morning.
10:49:35 Q. Is that based on the top
10:49:38 right-hand corner?
10:49:39 A. Yes.
10:49:43 Q. And relying on this document,
10:49:45 what history was provided to you as the
10:49:46 emergency room physician about Ms. Pickering
10:49:48 and her condition?
10:49:48 A. That she was a 78-year-old
10:49:54 woman from a nursing home. Do not resuscitate.
10:49:58 Found by nursing home staff unresponsive at
10:50:03 10:50 hours. Glucose was 0.4. Given D50W, so
10:50:10 1 amp -- that's basically sugar -- by EMS. The
10:50:15 sugar was then 4.6. Given second amp in 8.
10:50:23 So --
10:50:25 Q. When you say "the sugar was
10:50:29 4.6," what does that mean?
10:50:32 A. The sugar -- they must have
10:50:33 rechecked the sugar. And so it's risen with
10:50:36 the -- with the ambulance giving sugar.
10:50:39 Q. When you say "the sugar,"
10:50:41 what do you mean?
10:50:42 A. The blood sugar, sorry, the
10:50:43 patient's blood sugar. So originally, the
10:50:45 patient's blood sugar was 0.4. D50W is like
10:50:53 sugar water for -- that -- to inject into an
10:50:55 intravenous to bring up the blood sugar.
10:50:59 So an amp -- a dose of the D50W
10:51:09 was given by EMS, so by the ambulance service,
10:51:14 and the blood sugar rose to 4.6.

10:51:17 Q. And based on this record and
10:51:18 your general practice, can you tell us what
10:51:20 your involvement in Ms. Pickering's care would
10:51:24 have been on that day?
10:51:25 A. So based on this record,
10:51:27 she -- I see that she went into -- it says TR2
10:51:31 and room number, and that would be the trauma
10:51:34 room or resuscitation room. So that, to me,
10:51:36 indicates that she was quite sick or critical,
10:51:40 so it would be immediate attendance to the
10:51:43 bedside.
10:51:44 Q. And based on the record or
10:51:46 your general practice, can you confirm what
10:51:49 treatment you provided to Ms. Pickering on that
10:51:51 day?
10:51:51 A. In general, as I said, it
10:51:56 would be immediate attendance at the bedside,
10:51:58 information gathering, physical examination.
10:52:03 Generally, simultaneously, nurses would be
10:52:06 starting intravenouses if they -- I would
10:52:10 presume one was started by the ambulance since
10:52:11 they administered a dose of glucose, perhaps
10:52:16 the second one.
10:52:16 And then laboratory
10:52:18 investigations. And then looking at the
10:52:21 record, she had a CAT scan of the head.
10:52:23 Q. And I'll ask you -- if you
10:52:27 could slide down just slightly, please. I note
10:52:30 on the right-hand side of the page 17:00?
10:52:34 A. Yes.
10:52:34 Q. Can you confirm what that
10:52:36 entry states and pertains to?

10:52:38 A. That's an entry I made that I
10:52:42 discussed with the -- a nurse at the home, that
10:52:50 they're aware of -- status is comfort
10:52:57 medications, that they hold PO meds, so hold
10:52:59 oral medications.
10:53:00 I've written lorazepam 1
10:53:04 milligram, subqq 6H PRN, so she could have the
10:53:10 medication lorazepam and 1 milligram with an
10:53:14 injection under the skin -- just under the skin
10:53:17 every six hours, if needed.
10:53:19 And another medication,
10:53:23 hydromorphone, 1 milligram subcutaneously.
10:53:27 It's a bit cut off, but I think Q1H PRN, so
10:53:31 every hour if needed. And then DNR, do not
10:53:35 resuscitate.
10:53:36 Q. And why were those orders
10:53:39 given?
10:53:39 A. She remained unresponsive and
10:53:48 was in poor condition, so it was -- she -- we
10:53:55 turned to comfort measures or a palliative care
10:53:59 approach.
10:54:00 Q. And at the bottom of the page
10:54:02 under "Final Diagnosis on Discharge," what is
10:54:08 the entry?
10:54:09 A. Severe hypoglycemia.
10:54:10 Q. Was that your diagnosis?
10:54:12 A. That is my -- so I had a
10:54:16 resident working with me that day. That would
10:54:20 be their handwriting. But I've signed the
10:54:23 chart, so I agreed with the diagnosis.
10:54:25 Q. Why was that the diagnosis?
10:54:26 A. Because she had a very low

10:54:30 1 blood sugar of 0.4.
10:54:32 2 Q. You describe that as very
10:54:34 3 low?
10:54:34 4 A. Yes.
10:54:35 5 Q. What would a normal blood
10:54:38 6 sugar be in a nondiabetic patient?
10:54:41 7 A. About 4 to 6.
10:54:43 8 Q. If you could turn to Tab 28
10:54:47 9 of your document brief, please, Document 65222
10:54:52 10 and the third page of that document. And if I
10:55:05 11 could take you to the note on March 23rd at
10:55:09 12 17:11.
10:55:10 13 A. Okay.
10:55:11 14 Q. It states: [AS READ]
10:55:13 15 "Call received from Dr. Urbantke
10:55:15 16 from Woodstock Hospital at
10:55:19 17 17:00."
10:55:19 18 Do you have any recollection of this
10:55:20 19 discussion?
10:55:20 20 A. No. I presume it happened
10:55:23 21 because I wrote 17:00 on my emergency.
10:55:29 22 Q. Okay. And why would you have
10:55:31 23 contacted Caressant Care about Ms. Pickering?
10:55:33 24 A. I contacted them because we
10:55:44 25 couldn't explain the low blood sugar, and that
10:55:49 26 if she passed away, could a coroner be called.
10:55:53 27 Q. And I'll ask you to turn to
10:55:56 28 the second page in the document to an entry at
10:56:00 29 the bottom of the page, 17:21. There's another
10:56:08 30 note that says: [AS READ]
10:56:09 31 "Dr. Urbantke mentioned that
10:56:11 32 Maureen's blood sugar was

10:56:13 1 extremely low when she arrived
10:56:15 2 at the hospital, and the cause
10:56:16 3 is unknown. She stated that if
10:56:19 4 Maureen passes, it might be a
10:56:21 5 good idea to call the coroner on
10:56:23 6 this one."
10:56:23 7 So firstly, do you know if this was a separate
10:56:25 8 discussion or if they're one or two
10:56:29 9 conversations because there are two Progress
10:56:31 10 Notes?
10:56:31 11 A. I don't recall one way or the
10:56:34 12 other. I presume only one, but I'm not sure.
10:56:37 13 Q. And you don't recall?
10:56:39 14 A. Sorry?
10:56:40 15 Q. You said you don't recall?
10:56:41 16 A. I don't recall.
10:56:43 17 Q. Before I move on, I did just
10:56:48 18 want to confirm one point from the prior note
10:56:51 19 at the 17:11.
10:56:52 20 A. Okay.
10:56:52 21 Q. If you could turn back to
10:56:56 22 page 3, please. It indicates that -- the note
10:57:03 23 suggests that you reported: [AS READ]
10:57:05 24 "Maureen continues to be
10:57:07 25 unresponsive, and tests shows
10:57:10 26 the possibility of a 'midbrain
10:57:11 27 stroke.'"
10:57:12 28 What was that information based upon?
10:57:14 29 A. The CAT scan. If -- sorry.
10:57:21 30 Flipping back to my emergency record, there's a
10:57:25 31 note. It says: [AS READ]
10:57:29 32 "CT negative, CTA --"

10:57:32 Which is a -- so she had a regular CAT scan,
10:57:36 and then she had a CTA, a CAT scan angiography,
10:57:41 so they put dye through the vessels for a
10:57:47 different view. And it says: [AS READ]
10:57:52 "? infarct upon. Discussed with
10:57:55 power of attorney."
10:57:56 So that would be the possible mid vein (sic)
10:58:01 stroke.
10:58:01 Q. And then turning back to the
10:58:04 Progress Note at 17:21, please, on page 2,
10:58:11 there is a part in quotations there: [AS READ]
10:58:14 "Might be a good idea to call
10:58:16 the coroner on this one."
10:58:17 Is that something that you believe you would
10:58:20 have reported to a long-term care home?
10:58:22 A. I believe that was my
10:58:26 intention for the call, is to ask them to call
10:58:30 a coroner.
10:58:30 Q. And why would you have said
10:58:32 that?
10:58:33 A. Because she had the low blood
10:58:39 sugar that was unexplained.
10:58:40 Q. At that time, do you know
10:58:44 if -- or do you believe that you would have
10:58:45 been thinking about the possibility of
10:58:48 intentional harm?
10:58:49 A. I believe I was thinking more
10:58:52 along the line of a medication error.
10:58:55 Q. And do you have any other
10:58:57 information about these discussions with
10:59:00 Caressant Care?
10:59:00 A. No.

10:59:02 1 Q. And the final document I'll
10:59:06 2 ask you to turn to is the Affidavit of
10:59:10 3 Ms. Noelle Kelly, which was entered as
10:59:12 4 Exhibit 97 yesterday -- or, pardon me, on
10:59:15 5 Monday. If you could provide a copy to the
10:59:17 6 witness, please. And that's document AFF00018.
10:59:32 7 And the second page of the document, please.
10:59:35 8 For your benefit, Dr. Urbantke,
10:59:38 9 Ms. Kelly is an individual working at Ontario
10:59:39 10 dispatch -- the central dispatch, rather, and
10:59:41 11 she swore this Affidavit to help us understand
10:59:43 12 the I/CAD document recording her interactions
10:59:47 13 on the date of March 28th.
10:59:49 14 And if you note at paragraph
10:59:52 15 5(c), Ms. Kelly has provided evidence that at
10:59:57 16 8:37 on the morning of March 28th, she called
11:00:02 17 you to assign you the case as an investigating
11:00:07 18 coroner. Do you have any recollection about
11:00:09 19 being contacted by Ms. Kelly?
11:00:10 20 A. No.
11:00:10 21 Q. Do you have any recollection
11:00:11 22 of being contacted by central dispatch about
11:00:14 23 Ms. Maureen Pickering?
11:00:15 24 A. No.
11:00:16 25 Q. And the note indicates that
11:00:21 26 Ms. Kelly spoke to you and that you said the
11:00:28 27 blood sugar was less than 1 and unexplained,
11:00:30 28 that you can't take the case because you saw
11:00:32 29 her in the ER but will speak to the coroner to
11:00:35 30 give more background information. Urbantke has
11:00:35 31 declined the job. Why would you have declined
11:00:43 32 this case?

11:00:43 A. Because I actively treated
11:00:45 her recently, so I -- it's a -- to me, it would
11:00:48 be a conflict of interest, so that's why I
11:00:53 declined.
11:00:54 Q. And just as a point of
11:00:56 clarification again, the note at the quotation
11:00:58 indicates: [AS READ]
11:00:58 "Hospital two days ago."
11:01:02 You've reviewed the records and seen that
11:01:04 Ms. Pickering was in hospital on March 23rd?
11:01:07 A. Yes.
11:01:08 Q. And this call took place on
11:01:10 March 28th?
11:01:11 A. Yes.
11:01:12 Q. So will you agree with me
11:01:14 that Ms. Pickering was in hospital five days
11:01:16 prior, not two days prior?
11:01:17 A. Doing the math, yes.
11:01:19 Q. Okay. And the note indicates
11:01:22 that you had stated: [AS READ]
11:01:26 "Will speak to the coroner to
11:01:27 give more background
11:01:28 information."
11:01:28 Do you believe that's something you would have
11:01:30 said to provincial dispatch?
11:01:31 A. Yes.
11:01:32 Q. Do you have any knowledge or
11:01:35 information about whether you had any
11:01:37 subsequent discussions with provincial dispatch
11:01:39 about Ms. Pickering?
11:01:40 A. Not that I recall.
11:01:42 Q. Do you know or do you

11:01:43 1 remember if you spoke to the investigating
11:01:45 2 coroner about Ms. Pickering?
11:01:46 3 A. Not that I recall.
11:01:47 4 Q. Do you recall speaking to
11:01:48 5 Dr. George about Ms. Pickering at the time of
11:01:51 6 her death?
11:01:52 7 A. I don't recall.
11:01:52 8 Q. Do you believe presently it's
11:01:55 9 possible or not possible that you had any such
11:01:59 10 conversations?
11:01:59 11 A. I don't recall one way or the
11:02:02 12 other.
11:02:03 13 Q. There was just one point of
11:02:22 14 clarification I did want to make, Dr. Urbantke,
11:02:24 15 based on the testimony that you provided.
11:02:27 16 I'd asked you if there were
11:02:29 17 certain types of cases wherein an autopsy was
11:02:33 18 required. Do you remember me asking you that
11:02:35 19 question?
11:02:35 20 A. Yes.
11:02:36 21 Q. And if I and Ms. Jones have
11:02:40 22 our notes correctly, I believe you indicate in
11:02:42 23 your response certain types of cases would
11:02:44 24 include a homicide or an accident?
11:02:47 25 A. I did say that, and I will
11:02:49 26 say thinking back on my answer, I can't say 100
11:02:53 27 percent of the cases an accident. I was -- I
11:02:59 28 will admit, I was probably thinking car
11:03:01 29 accident in that.
11:03:02 30 But if a person has fallen and
11:03:06 31 has had a fractured hip and they have a
11:03:10 32 well-documented history, it's going to be an

11:03:13 accident. Manner of death will be accident,
11:03:15 but I will not necessarily write -- do an
11:03:18 autopsy in that case.
11:03:19 Q. Okay.
11:03:22 MS. ROBINSON: Thank you. Those
11:03:23 are my questions for you at this
11:03:24 stage. And Ms. Bambers on
11:03:27 behalf of the Province will have
11:03:29 some additional questions for
11:03:32 you.
11:03:32 EXAMINATION-IN-CHIEF BY
11:03:32 MS. BAMBERS:
11:03:47 Q. Good morning, Dr. Urbantke.
11:03:50 I have a few questions for you. I know that
11:03:57 you said that the number of calls you get is so
11:04:00 variable that it was difficult -- or you were
11:04:04 unable to estimate the number of cases where
11:04:08 you get the call from central dispatch, and
11:04:12 then you have to make an assessment of whether
11:04:15 to investigate, but you don't investigate.
11:04:17 So that number you were not able
11:04:19 to estimate; correct?
11:04:20 A. Correct.
11:04:21 Q. But leaving aside a specific
11:04:27 number -- I mean, this happens more than
11:04:31 occasionally. It must be a regular thing in
11:04:33 your practice?
11:04:37 A. I would say more than
11:04:39 occasionally. It's -- I can't --
11:04:43 Q. I mean, you would have had at
11:04:46 least ten situations where you've had to assess
11:04:49 and not investigate it?

11:04:50 A. Yes.
11:04:51 Q. In your entire career or --
11:04:55 A. Yeah, probably within a year
11:05:00 even or it -- once again, it's variable, so
11:05:03 it's hard to put a hard-and-fast number, but
11:05:03 certainly I've done it before, yes.
11:05:05 Q. You've done it many times
11:05:05 probably --
11:05:05 A. Yes.
11:05:08 Q. -- to get to the 50 that you
11:05:10 do investigate? Is that going too far?
11:05:13 A. "Many" is sort of --
11:05:14 Q. More than occasional?
11:05:15 A. More than occasional for
11:05:17 sure.
11:05:18 Q. Okay. And when you do that
11:05:24 head-to-toe examination of a body when you are
11:05:28 investigating a death, I just wanted to clarify
11:05:30 that you're not taking any samples of body
11:05:33 fluids or anything like that?
11:05:34 A. No.
11:05:35 Q. Or tissues?
11:05:36 A. No.
11:05:36 Q. That's not included?
11:05:37 A. No. It's a physical exam.
11:05:41 Q. All right. And you indicated
11:05:48 that if you are unable to determine the cause
11:05:52 of death on the balance of probabilities, that
11:05:56 you would order an autopsy?
11:06:00 A. Yes.
11:06:00 Q. And I just wanted to clarify.
11:06:03 Do you always go ahead with that, or would you

11:06:08 consult with the pathologist as to what an
11:06:14 autopsy could reveal before you order an
11:06:17 autopsy?
11:06:17 A. I -- it's my practice to call
11:06:19 the pathologist and discuss the case with the
11:06:22 pathologist.
11:06:23 Q. Right. And that may
11:06:26 influence whether you decide to order the
11:06:29 autopsy?
11:06:29 A. I would say in general, I've
11:06:38 probably decided to order the autopsy, and it's
11:06:41 more information exchange, and then if -- to
11:06:44 help them understand the investigation better,
11:06:48 we do do a warrant, but -- and that allows them
11:06:52 to ask questions, and then if they need more
11:06:54 information that I don't have at the time, I
11:06:55 can try to get it for them.
11:06:56 Q. Are there cases where you may
11:07:00 call the pathologist just to get advice before
11:07:03 you decide to order an autopsy?
11:07:05 A. Yes. The other person that I
11:07:10 could call for advice would be the regional
11:07:12 supervising coroner on call. I would probably
11:07:16 start with them.
11:07:16 Q. And my friend had asked you
11:07:31 about when you're doing a threshold death
11:07:33 investigation, investigating the tenth death,
11:07:41 whether it was an expectation that you look
11:07:44 back at those previous nine charts, and your
11:07:47 answer was that you were not aware.
11:07:49 And I just wanted to clarify
11:07:54 what you meant by that, that you're -- are you

11:07:56 saying that you're not expected to look at
11:07:59 those charts of those previous nine deaths?
11:08:03 A. I'm not aware of a
11:08:07 hard-and-fast rule that you have to pull each
11:08:10 individual chart.
11:08:10 Q. All right. And Ms. Robinson
11:08:20 had showed you the Caressant Care death
11:08:25 registry where you were investigating the tenth
11:08:30 death. Maybe we could bring up that death
11:08:34 registry. It's Document 71977.
11:08:55 So you were investigating the
11:08:57 tenth death on July 21st, 2013, and you believe
11:09:05 you would have reviewed the death registry
11:09:09 where Helen Young's name appeared on it.
11:09:14 And you indicated that you
11:09:15 couldn't say at this time whether you would
11:09:20 have pulled those charts; correct?
11:09:22 A. I can't say one way or the
11:09:24 other.
11:09:24 Q. I wanted to take you to
11:09:27 Document 71443. So this is a Coroner
11:09:46 Investigation Statement that appears you
11:09:48 completed and that you completed it on July 21,
11:10:00 2013.
11:10:03 So this would be the death
11:10:05 investigation -- the threshold death
11:10:07 investigation that you were doing where you
11:10:12 would have looked back at Helen Young?
11:10:14 A. I would presume so.
11:10:15 Q. All right. And if we could
11:10:18 go to the end of the form, in the last
11:10:29 paragraph, it says: [AS READ]

"The death register was reviewed, and although there were a few pieces of missing data, no issues were identified. The staff was made aware of the register deficiencies."

Does that assist you to recall what you would have done on this threshold death investigation and to what extent you would have looked back at the other cases?

A. I can't speak to this specific one, but in general, if there's missing data, like, the cause of death isn't written in or the date of death, I make the staff aware and ask them that it needs to be filled in and then have it usually faxed to me so that I can review when it's complete.

Q. All right. But I'm suggesting -- or I'm asking you that if you had done something more with those other deaths, would you have documented it in some way? Like, would you have noted something unusual about the prior deaths here beyond what you wrote here?

A. If there's something unusual, I would presume I would have noted it.

Q. All right. Regarding your death investigation of Wayne Hedges, you have no information as to -- I take it you have no information as to when his body went to the funeral home beyond anything stated in the notes?

11:12:07 A. Just what the record -- that
11:12:09 record that was up.
11:12:10 Q. All right. And are there
11:12:11 times when you've examined the body elsewhere,
11:12:13 like, in a funeral home?
11:12:15 A. I have, in the past, examined
11:12:20 a body at the -- at a funeral home, yes.
11:12:23 Q. And on those occasions with
11:12:31 the Medical Certificate of Death, if you've
11:12:33 disagreed with the cause of death and you have
11:12:35 to create a new one, do you discuss it with the
11:12:40 doctor who had done the original one?
11:12:42 A. In general. Can I say it's
11:12:44 100 percent of the time? No. It depends on
11:12:47 being able to contact him. But, yes, in
11:12:51 general.
11:12:55 MS. BAMBERS: Thank you.
11:12:57 THE COMMISSIONER: Thank you,
11:12:58 Ms. Bambers.
11:13:04 MS. ROBINSON: Commissioner, I'd
11:13:05 propose that perhaps we take the
11:13:07 morning recess now before the
11:13:09 cross-examination of
11:13:10 Dr. Urbantke begins.
11:13:11 THE COMMISSIONER: Yes.
11:13:12 Thank you very much. Who's up
11:13:13 after the break?
11:13:15 MS. ROBINSON: Mr. Van Kralingen
11:13:16 will begin.
11:13:16 THE COMMISSIONER: Thank you.
11:13:17 Is there a document brief as
11:13:20 usual?

11:13:21 MR. VAN KRALINGEN: Yes.
11:13:21 THE COMMISSIONER: May I have it
11:13:23 over the break, please?
11:13:25 MR. VAN KRALINGEN: Sure. I can
11:13:26 tell you that there's only a
11:13:27 small number of documents I'm
11:13:28 going to refer to, so I would
11:13:30 suggest starting at Document
11:13:31 Number 4.
11:13:31 THE COMMISSIONER: Thank you.
11:13:57 THE REGISTRAR: This Public
11:14:07 Inquiry is on recess for 15
11:14:12 minutes.
11:14:13 -- RECESSED AT 11:14 A.M. --
11:31:46 -- RESUMED AT 11:31 A.M. --
11:31:47 MS. BAMBERS: Commissioner, I
11:31:48 did complete my examination, but
11:31:51 I did neglect to mark one
11:31:55 document as an exhibit, and that
11:31:56 was the last document referred
11:31:57 to, Document 71443, which was
11:32:03 the Coroners Investigation
11:32:06 Statement completed by
11:32:07 Dr. Urbantke on July 21st, 2013.
11:32:12 If I could have that marked as
11:32:14 an exhibit.
11:32:14 THE COMMISSIONER: Right. It
11:32:15 hasn't been entered as an
11:32:17 exhibit then otherwise.
11:32:19 Thank you very much.
11:32:20 So, Madam Clerk, where are we
11:32:22 at on exhibits?

THE REGISTRAR: That would be 113.
THE COMMISSIONER: Exhibit 113 then, the Coroners Investigation Statement, Form 3, dated 2013. Thank you.
MS. BAMBERS: Thank you.
EXHIBIT NO. 113: Coroners Investigation Statement completed by Dr. Urbantke, dated July 21, 2013.
THE COMMISSIONER:
Mr. Van Kralingen?
MR. VAN KRALINGEN: Good morning, Commissioner.
THE COMMISSIONER: Good morning.
CROSS-EXAMINATION BY
MR. VAN KRALINGEN:
Q. Good morning, Dr. Urbantke. We met briefly earlier this morning. My name is Alex Van Kralingen. I'm one of the lawyers representing one of the victims groups here.
And you have a copy of the document I provided? Great.
Before we get into the documents, I was a little unclear this morning in terms of how you would characterize how much coroners work you do as part of your practice.
Could you estimate the percentage of time you spend on coroners activities in your practice?
A. On an investiga -- I'm also

11:33:21 an inquest coroner, so -- but on
11:33:25 investigations, probably less than 10 percent.
11:33:30 Q. Fair enough. If you go to
11:33:32 Tab 4 of the documents you have in front of
11:33:34 you. That is Document 65222.
11:33:36 MR. VAN KRALINGEN: I've just
11:33:37 provided, Commissioner, only two
11:33:39 pages of Ms. Pickering's
11:33:43 Progress Notes.
11:33:43 THE COMMISSIONER: Thank you.
11:33:45 BY MR. VAN KRALINGEN:
11:33:45 Q. On the second page, at the
11:33:47 bottom, you've already reviewed this entry with
11:33:51 Ms. Robinson this morning. It's the entry
11:33:53 where you say:
11:33:55 "If Maureen passes, it 'might be
11:33:57 a good idea to call the coroner
11:33:59 on this one.'"
11:34:00 And I recognize that that's Ms. Wettlaufer
11:34:03 capturing what she believes you said on a phone
11:34:05 call. And I know this is not your note.
11:34:08 My question to you is this:
11:34:10 Assuming that you had made that statement, in
11:34:12 your career, have you ever previously suggested
11:34:15 to another health care provider that it might
11:34:19 be a good idea to call the coroner in
11:34:25 connection with a pending death?
11:34:25 A. I can't say one way or the
11:34:30 other. It may be in the circumstances like
11:34:34 that fall -- the fall -- the fall example I
11:34:39 gave you, but I would say it's probably
11:34:43 unlikely -- unusual. It'd be infrequent.

11:34:49 Q. You're suggesting it's a rare
11:34:51 occurrence?
11:34:51 A. Yes.
11:34:51 Q. All right. And assuming that
11:34:52 you made that statement, I assume that the
11:34:55 concern was motivated because Ms. Pickering's
11:34:58 severe hypoglycemia was unexplained; is that
11:34:58 fair to say?
11:35:01 A. From the notes, yes, I would.
11:35:04 Q. Okay. And from the notes, I
11:35:06 assume that you were -- you would assume that
11:35:09 there would have been no good reason to explain
11:35:11 the severe hypoglycemia. Would you agree with
11:35:13 that?
11:35:13 A. I didn't have one at the
11:35:16 time.
11:35:16 Q. Fair enough. At that
11:35:18 point -- and we discussed this this morning --
11:35:21 Ms. Pickering goes back to Caressant Care
11:35:23 Woodstock in a palliative state. Do you
11:35:26 remember talking about that this morning?
11:35:27 A. Yes.
11:35:27 Q. Given what you've seen in
11:35:31 Ms. Pickering's records, if you had made a
11:35:33 comment that it might be a good idea to call
11:35:35 the coroner, to your mind, would that advice
11:35:39 have changed whether Ms. Pickering died one day
11:35:41 later or three days later or five days later?
11:35:45 A. No.
11:35:46 Q. Thank you. Can you go to the
11:35:48 next tab in the document, Tab 5. And this is
11:35:54 Document 65223. It's the copy of the emergency

11:36:03 1 record that you discussed earlier this morning
11:36:04 2 with Ms. Robinson. And if you could go to page
11:36:09 3 85, please. Thank you.
11:36:14 4 Before we look at this record,
11:36:16 5 I'm wondering, in the course of your education
11:36:19 6 and ongoing training as a coroner, if you've
11:36:24 7 ever talked about the idea of an insulin
11:36:27 8 injection possibly leading to death?
11:36:29 9 A. Yes.
11:36:35 10 Q. Right. And I want to be
11:36:36 11 clear. I'm not speaking about necessarily a
11:36:39 12 nefarious act, or it could be a medication
11:36:42 13 error, for example.
11:36:43 14 A. Correct.
11:36:43 15 Q. Just so I'm clear, in the
11:36:45 16 course of your continuing education, you've
11:36:49 17 expressly discussed that?
11:36:50 18 A. I remember a case being
11:36:51 19 presented during one of the conferences. I
11:36:54 20 can't recall which one.
11:36:55 21 Q. Fair enough. And I'm not
11:36:57 22 asking for which conference. I'm wondering if
11:37:00 23 you could provide as much detail as possible
11:37:02 24 about the case that was presented.
11:37:03 25 A. I remember it was an acute
11:37:09 26 care hospital, and it was described that a
11:37:14 27 patient received an injection -- well, in --
11:37:19 28 that's what they figured happened, is that the
11:37:22 29 patient -- wrong patient received an injection
11:37:25 30 of insulin and caused, like, low blood sugar,
11:37:32 31 but --
11:37:34 32 Q. Which ultimately led to their

11:37:36 death?
11:37:36 A. Yes.
11:37:36 Q. Okay. Do you believe it's
11:37:40 possible that you had engaged in that education
11:37:42 or heard about this case before you dealt with
11:37:47 Ms. Pickering in 2014?
11:37:51 A. I believe so.
11:37:52 Q. Do you think it's possible
11:37:56 that your memory of that case might have
11:37:59 triggered a comment to Ms. Wettlaufer that it
11:38:03 might be a good idea to call a coroner on this
11:38:06 one?
11:38:06 A. I don't recall specifics, but
11:38:10 I believe so.
11:38:11 Q. If Ms. Pickering died shortly
11:38:14 after you had provided this note to
11:38:20 Ms. Wettlaufer that it might be a good idea to
11:38:22 call the coroner on this one, is it fair to say
11:38:24 that either way, you thought it would be
11:38:26 important to get to the bottom of why
11:38:27 Ms. Pickering had this severe hypoglycemia?
11:38:30 A. Yes.
11:39:03 MR. VAN KRALINGEN: Thank you
11:39:03 for your time today. Those are
11:39:05 all of my questions.
11:39:13 THE WITNESS: Thank you.
11:39:13 THE COMMISSIONER: Thank you,
11:39:17 Mr. Van Kralingen.
MS. ROBINSON: Mr. Scott on
behalf of other of the family
groups.
THE COMMISSIONER: Thank you.

MR. SCOTT: Good morning, Commissioner.
11:32:47 THE COMMISSIONER: Good morning, Mr. Scott.
11:32:47 CROSS-EXAMINATION BY MR. SCOTT:
11:32:47 Q. Good morning, Dr. Urbantke. I'm Paul Scott. I represent one of the other family groups here.
11:39:21 A. Okay.
11:39:23 Q. I just have a few questions for you. I'd just like to pick up on where my friend left off with you on Maureen Pickering's case.
11:39:24 When you discharged her back to Caressant Care after treating her in the emergency room, you'd stabilized her blood sugar at that point; correct?
11:39:26 At that point, you weren't thinking anybody was trying to kill her; correct?
11:39:28 A. Sorry, can you -- I just --
11:39:32 Q. At that point, you hadn't thought to yourself somebody is trying to kill this woman with insulin; correct?
11:39:34 A. Not that I recall.
11:39:37 Q. You would recall that if you'd thought it, don't you think?
11:39:46 A. I would think so.
11:39:50 Q. I would think so too.
11:39:52 So when you sent her back to the nursing home, were you thinking to yourself then somebody has made a medication error here,
11:39:53
11:39:53
11:39:56
11:39:58
11:39:59
11:40:02
11:40:02
11:40:02
11:40:02
11:40:05
11:40:05
11:40:07
11:40:08
11:40:11

11:40:14 and that's probably why this lady has such a
11:40:16 low blood sugar?
11:40:18 A. That would be, I think, my
11:40:19 thought process at the time.
11:40:20 Q. Sure. And when you sent her
11:40:22 back, did you send back a note to say, "You
11:40:25 should do a little investigation. There may
11:40:28 have been a medication error"?
11:40:29 A. I think that was the intent
11:40:33 on my phone call. I can't recall exactly what
11:40:36 was discussed.
11:40:36 Q. Your phone call to whom?
11:40:39 A. The nursing home.
11:40:39 Q. So when you discharged
11:40:44 Ms. Pickering back to Caressant Care that day,
11:40:46 do you recall calling the nursing home before
11:40:49 she went back to say, "There may have been a
11:40:52 medication error"?
11:40:52 A. I don't have any -- I -- just
11:40:55 from the notes that I made that I called it --
11:41:00 I discussed with the nurse at 17:00 and then
11:41:03 the notes from the nursing home that I
11:41:05 discussed.
11:41:07 Q. Which leads me to my next
11:41:09 question which is is there a system whereby you
11:41:12 would make a note and send it back with the
11:41:15 ambulance crew to the nursing home?
11:41:18 A. My -- the -- I will admit,
11:41:23 the nurses in the emergency department usually
11:41:27 package up notes and things, but my
11:41:29 understanding is a copy of my face sheet, so
11:41:32 that emergency record, would go -- be

11:41:36 photocopied and sent back.
11:41:37 Q. Okay. I just want to
11:41:44 again -- maybe I'm just not understanding this
11:41:46 process very well. I'm going to call it a
11:41:49 threshold, a different threshold than the ten
11:41:53 cases.
11:41:53 When you get a call from
11:41:54 dispatch in Toronto about a coroners case,
11:42:00 somebody has died --
11:42:00 A. Okay.
11:42:02 Q. -- I'm going to call this
11:42:03 point a threshold. This is when you have to
11:42:06 decide do I investigate this case or do I not
11:42:11 investigate this case; correct? You have to
11:42:13 make that decision?
11:42:13 A. I wouldn't make it just -- if
11:42:17 I'm not available, I would tell dispatch I'm
11:42:19 not available, but I wouldn't make it just in
11:42:21 discussing with --
11:42:23 Q. No, fair enough. So let's
11:42:26 say you're available --
11:42:26 A. Yeah.
11:42:27 Q. -- and you say, "Yes, okay, I
11:42:28 can take this case."
11:42:29 A. Okay.
11:42:30 Q. And then you take certain
11:42:31 steps to decide whether to proceed with an
11:42:34 investigation or not; correct?
11:42:36 A. Correct.
11:42:36 Q. And you've gone through what
11:42:40 some of those steps are for us. And one of the
11:42:44 things I wanted to ask you about is the medical

11:42:46 records.
11:42:47 What medical records can you or
11:42:50 do you access before you decide whether to make
11:42:54 an investigation or not?
11:42:55 A. It would depend. I could
11:43:08 access --
11:43:09 Q. Would it assist if I say
11:43:11 we're only dealing with a long-term care home
11:43:14 case?
11:43:14 A. Unless I went into the
11:43:17 long-term care facility, I wouldn't have access
11:43:20 to -- direct access to their records.
11:43:22 Q. Okay. So you don't have any
11:43:23 medical documents to review in order to decide
11:43:25 whether you're going to investigate or not?
11:43:26 A. Not in front of me.
11:43:28 Q. Okay. So for my
11:43:31 clarification, what do you use?
11:43:33 A. It's the discussions with
11:43:37 other -- with the individual on the phone or if
11:43:40 I speak to other people, depending on the
11:43:44 investigation.
11:43:44 Q. Again, I want to stop you.
11:43:46 If we're just in the long-term care home --
11:43:46 A. Yes.
11:43:49 Q. -- you would speak to the
11:43:51 person that called dispatch; am I correct?
11:43:54 A. Yes.
11:43:55 Q. And who else would you speak
11:43:56 to in the home before you decide whether you're
11:43:58 going to investigate or not?
11:44:00 A. Potentially the family, but

those would be the two big people in the home.
Q. Fair enough. And anything else?
A. It depends on the case. I could speak -- call the family doctor also.
Q. And in your experience, do you usually call the family doctor for a long-term care home case?
A. I wouldn't say "usually."
Q. Frequently?
A. Occasionally.
MR. SCOTT: Thank you. Those are my questions.
THE COMMISSIONER: Thank you, Mr. Scott.
MS. ROBINSON: Ms. Meadus is up next.
THE COMMISSIONER: Thank you.
CROSS-EXAMINATION BY MS. MEADUS:
Q. Good morning.
A. Good morning.
Q. My name is Jane Meadus, and I'm here on behalf of the Ontario Association of Residents' Councils. And I don't know if -- are you familiar with this organization?
A. Not entirely.
Q. Okay. So as you may be aware, every long-term care home has a Residents' Council within it, and this is the umbrella organization representing those organizations.
So we represent basically the

11:45:18 78,000 or so residents of long-term care in
11:45:21 Ontario through that organization.
11:45:23 A. Okay.
11:45:23 Q. Okay. So you are aware that
11:45:28 there's Residents' Councils in homes; is that
11:45:30 correct?
11:45:30 A. I've heard the -- I don't
11:45:32 deal with them a lot other than because I'm an
11:45:34 emergency physician, but it's familiar.
11:45:37 Q. So you don't provide any
11:45:38 direct services in long-term care homes?
11:45:42 You're not a family physician who provides
11:45:45 direct services in homes; is that correct?
11:45:47 A. That's correct.
11:45:47 Q. So is your attendance in
11:45:49 those homes specifically as a coroner?
11:45:50 A. Yes.
11:45:51 Q. Okay. Now, are you aware of
11:45:53 the mandatory reporting obligations under the
11:45:55 Long-Term Care Homes Act to report to the
11:45:58 Ministry of Health things like abuse or neglect
11:46:02 in a long-term care home?
11:46:04 A. I can't say I would -- I
11:46:07 can't say I know the specific regulation or --
11:46:10 Q. Okay. Have you ever reported
11:46:11 a case to the Ministry of Health that you've
11:46:14 come across?
11:46:15 A. For abuse or neglect?
11:46:18 Q. Yes.
11:46:19 A. Not that I recall. I've
11:46:22 spoken to inspectors.
11:46:25 Q. And what would be the contact

11:46:28 speaking with an inspector?
11:46:29 A. I can't recall. And I don't
11:46:31 know if it was related to this facility or not.
11:46:34 Q. Okay. So I'd like to bring
11:46:36 up exhibit 0007803, which is Mr. Hedges', I
11:46:50 hope.
11:47:03 So you've talked today about
11:47:05 what your usual practice is; correct? And you
11:47:08 don't have a recollection other than what
11:47:11 you've seen in the documentation; is that
11:47:13 correct?
11:47:13 A. Correct.
11:47:13 Q. Okay. So I'd like to bring
11:47:17 down a little bit farther. And just stop
11:47:19 there, please. So it says at 1:56 a.m.:
11:47:19 [AS READ]
11:47:23 "Call received from Dr. Urbantke
11:47:23 --"
11:47:26 I guess that's supposed to be you. [AS READ]
11:47:27 "-- coroner on call. She stated
11:47:29 she would not be able to be in
11:47:31 to pronounce the death until
11:47:33 morning at the earliest, but
11:47:35 likely not until early
11:47:37 afternoon. She states she will
11:47:38 require Wayne's chart and the
11:47:38 death register. She requested I
11:47:40 call the physician on call and
11:47:43 have them pronounce the death
11:47:44 instead. Dr. Miettinen informed
11:47:45 and will be in in the morning.
11:47:46 Wayne's mother informed."

11:47:49 Okay. So do you recollect that phone call?
11:47:51 A. No.
11:47:51 Q. And you would have reviewed
11:47:53 the chart; is that correct?
11:47:54 A. In preparation for --
11:47:56 Q. When you were doing the
11:47:58 investigation itself.
11:48:00 A. Yes.
11:48:00 Q. And so would this note likely
11:48:02 have been in that chart if you didn't come in
11:48:05 right at that time?
11:48:05 A. I would presume so.
11:48:07 Q. Okay. So you didn't disagree
11:48:09 with anything that you saw in the chart; is
11:48:12 that correct?
11:48:12 A. No.
11:48:12 Q. So we know that you were
11:48:14 called at 1:56. Dr. Miettinen pronounced death
11:48:22 at 8:05. Do you have any recollection at all
11:48:26 whether you came in the morning or that
11:48:27 afternoon?
11:48:28 A. No.
11:48:28 Q. Okay. Can I have exhibit
11:48:32 69423, please. Sorry, document number. Yes, I
11:48:44 found I had done that yesterday. I wrote
11:48:46 exhibit instead of document. Can you just go
11:48:48 down that page a little bit? Okay.
11:48:51 And so, first of all, we do know
11:48:53 this is a threshold death, correct, that you
11:48:55 were in for this? It's just up a little bit
11:48:57 farther. Is that correct?
11:49:02 So this is the reason you were

being called. It says under "involvements": [AS READ]

"Long-term care facility threshold."

A. It was a threshold death.

Q. Okay. And can you go down a little bit farther, please. Yeah, to the next page.

And right at the end of that first line, it says: [AS READ]

"Family had no concerns."

And do you have any specific recollection of speaking to them?

A. Not one way or the other.

Q. Okay. Thank you. And can you go down to the written notes, which I believe are on page 3.

Now, these are your notes that you took contemporaneously; is that correct?

A. Yes.

Q. So is there any documentation on that that you spoke with the family?

A. What tab? Sorry, I just can't see the whole document at once.

Q. Tab 16. Sorry, we don't have access to those numbers.

A. I don't see any note.

Q. Okay. The other question that was asked -- another question that was asked this morning had to do with when the body was released; is that correct? That you were asked, I believe, if it was released to the

11:50:22 funeral home, if you had seen the body before
11:50:25 it was released to the funeral home. Do you
11:50:27 remember that question this morning?
11:50:27 A. Yes.
11:50:28 Q. Okay. And in my review of
11:50:30 the witness statement that you had before --
11:50:35 MS. JONES: Sorry, Commissioner,
11:50:36 under the rules of the Public
11:50:38 Inquiry, the witness statements
11:50:40 aren't to be used for
11:50:41 cross-examination, so I just ask
11:50:42 my friend to remember that.
11:50:42 MS. MEADUS: Okay. Thank you.
11:50:44 BY MS. MEADUS:
11:50:44 Q. Okay. So I have looked for a
11:50:45 document that indicated -- and I understand --
11:50:48 are you not supposed to sign a document to
11:50:51 release the body? Would that be normally what
11:50:55 is done?
11:50:55 A. To the funeral home?
11:51:01 Q. Yes. If you're
11:51:03 investigating, do you have to release the body
11:51:06 to go to the funeral home?
11:51:07 A. Like, sign an actual
11:51:07 document?
11:51:07 Q. Yes.
11:51:08 A. Not necessarily.
11:51:09 Q. Not necessarily. Okay. So
11:51:09 how does the body get released then?
11:51:11 A. I would say they can -- they
11:51:16 would be -- you know, the body can be released
11:51:20 to the funeral home. It would be directed.

11:51:24 Q. If it's a coroners case, should they be releasing the body before you arrive?
11:51:32 A. No.
11:51:32 Q. Okay. But we don't know when the body was released in this -- whether you saw it before it was released in this case?
11:51:34 A. I don't know.
11:51:36 Q. You can't say. Okay. Thank you.
11:51:36 I'd like to talk to you a little bit about Maureen Pickering. So at the time you did -- we've just heard that you expressed concern about the hypoglycemia; is that correct? And that was why you had indicated that you thought it might be a coroners case?
11:51:46 A. Yes.
11:51:55 Q. Okay. Now, one of the things that you indicated this morning -- and maybe you can just help me understand what the process -- she was brought to the hospital by ambulance; is that correct?
11:51:59 A. Yes.
11:52:02 Q. Okay. And you stated this morning that she received, I believe, an ampule of the D50W in the ambulance; is that correct?
11:52:04 A. Can I have the --
11:52:06 Q. Oh, sorry. That would be Tab 27.
11:52:09 A. From the notes.
11:52:10 Q. 65223. I apologize. Page 85.
11:52:11
11:52:13
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11:52:33
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11:52:44
11:52:46
11:52:47
11:52:57

11:52:57 A. Do you want me to wait or --
11:53:00 Q. Yes, please.
11:53:01 A. Okay. Sorry, can you repeat
11:53:17 the question again?
11:53:18 Q. I was just trying to
11:53:19 understand -- I understand there were 2 amps of
11:53:22 the D50W given.
11:53:24 A. Yes.
11:53:24 Q. My understanding from your
11:53:25 testimony this morning was that one was given
11:53:30 by the ambulance personnel. And I didn't
11:53:33 understand that myself before, so I'm just
11:53:35 wondering if you can just explain. Is that
11:53:37 what had happened according to your notes?
11:53:39 A. According to these notes,
11:53:41 it's -- so you'll see -- I guess it's the third
11:53:46 line down in the big block. The first line
11:53:51 says 78. So it says 10:50 hours. Just above
11:53:54 it, glucose 0.4 given D50W 1 amp by EMS. EMS,
11:54:04 the paramedics or --
11:54:04 Q. And so it says that the
11:54:05 glucose was 0.4. So would they have done some
11:54:10 type of test in the ambulance?
11:54:12 A. I would assume, since they
11:54:14 had a reading, they did a glucometer reading.
11:54:18 Q. Okay. What's a glucometer
11:54:17 reading?
11:54:18 A. The finger prick. You'll see
11:54:22 diabetics use a finger prick to take a little
11:54:26 piece of blood.
11:54:26 Q. And being an emergency room
11:54:29 physician, I'm assuming that you deal with the

11:54:32 ambulance staff all the time; is that correct?
11:54:34 A. Yeah.
11:54:34 Q. And do you supervise those
11:54:36 staff as well?
11:54:36 A. Do you mean, like, do I
11:54:38 provide them over --
11:54:40 Q. No, no, with -- my
11:54:41 understanding is that ambulance services, they
11:54:44 have to have, like, a hub there where there's a
11:54:47 physician that gives them some type of
11:54:51 directions.
11:54:51 A. No. I believe for our
11:54:52 county, it's out of London, but I -- I'm not
11:54:56 sure.
11:54:56 Q. You're not sure. Okay.
11:54:58 Do you have any knowledge as to
11:54:59 whether taking a glucose reading would be
11:55:03 something that ambulance professionals would do
11:55:06 to every patient, or would this be something
11:55:09 that they would do only in particular
11:55:11 instances?
11:55:12 A. I don't know their specific
11:55:14 protocols.
11:55:14 Q. Okay. Is it something you
11:55:15 see very often on an emergency chart?
11:55:18 A. It's not infrequent.
11:55:20 Q. Not infrequent?
11:55:21 A. It depends on the
11:55:22 circumstances.
11:55:23 Q. Okay. Circumstances. So
11:55:24 would you agree with me that something
11:55:26 triggered them to believe there might be a

11:55:29 problem with the insulin; that's why they
11:55:32 had --
11:55:33 MS. ROBINSON: I'm just going to
11:55:34 rise. I don't know that that's
11:55:36 something that Dr. Urbantke can
11:55:38 speak to.
11:55:39 MS. MEADUS: Okay. Thank you.
11:55:39 I'll move on. Thank you.
11:55:41 BY MS. MEADUS:
11:55:41 Q. So you had indicated you were
11:55:44 concerned about the hypoglycemia. And we
11:55:46 expect to hear from Dr. Pollanen later, and
11:55:51 he's the chief forensic pathologist for
11:55:58 Ontario.
11:55:58 And we're expecting him to talk
11:55:59 about the issue that in mild hypoglycemia,
11:55:59 symptoms are confusion, pallor, diaphoresis,
11:56:08 shakiness, irritability, anxiety, tachycardia,
11:56:08 dizziness, headaches, weakness, and a reduced
11:56:10 level of consciousness, but in severe
11:56:12 hypoglycemia, there can be irreversible brain
11:56:16 damage with coma and death, which is called
11:56:20 hypoglycemic encephalopathy.
11:56:20 And persons with hypoglycemic
11:56:22 encephalopathy may appear to have had a stroke
11:56:24 both in terms of clinical presentation and
11:56:26 imaging.
11:56:27 So is this the type of thing
11:56:28 that you were thinking about when you were
11:56:30 referring that back to the coroner; this is the
11:56:35 kind of finding that you might expect?
11:56:40 A. I'm not -- I'm not sure

what --

Q. I guess what I'm just trying to get at is, you know, would you have -- you had something -- you had a CT scan that indicated potential -- some kind of brain pons -- infarct or pons; correct?

A. That's what it says, yeah.

Q. But is it also possible that that could be mimicked by some type of hypoglycemic issue? Were you aware of that?

A. Well, I wrote "severe hypoglycemia" as my diagnosis.

Q. All right. Okay. Thank you. Okay. I'd like to turn your attention to another Form 3. And it's 71441. This is not in evidence. I will provide that to you.

Okay. So this is a document, and it appears to be dated in the bottom corner November the 28th, 2011. Do you see that?

A. I see that.

Q. Okay.

MS. BAMBERS: That's not the date.

MS. MEADUS: Pardon?

MS. BAMBERS: That's the date it was QA, so...

MS. MEADUS: I'm not sure what QA means, so...

MS. BAMBERS: Well, I guess approved.

MS. MEADUS: Approved. Okay.

MS. BAMBERS: Not the date of

the --
MS. MEADUS: Not the date of the document.
11:58:13 BY MS. MEADUS:
11:58:13 Q. And it appears to be -- it's got a statement date at the top of 2011. And
11:58:14 the only -- I don't think it really matters
11:58:18 that we know the exact date for this. I think
11:58:20 it's just important we know that it was in
11:58:22 2011.
11:58:24 So this would be a document
11:58:24 that -- it would be in 2011; is that correct?
11:58:25 A. It appears so.
11:58:27 Q. Okay. And that you were the
11:58:29 coroner on this?
11:58:31 A. Yes.
11:58:32 Q. Okay. And you can look down,
11:58:33 and you can see under "Involvements," it says:
11:58:36 [AS READ]
11:58:36 "Long-term care facility
11:58:41 threshold."
11:58:42 So this would have been a threshold death; is
11:58:42 that correct?
11:58:45 A. Correct.
11:58:45 Q. Okay. So my understanding is
11:58:46 is that you would have been looking at this
11:58:47 specific death, and then you have the narrative
11:58:49 there. And you went through your process.
11:58:50 And at the bottom of the page,
11:58:53 it says you had -- no concerns in regards to
11:58:54 care were expressed; is that correct?
11:58:57 A. I wrote that at the --
11:59:02

11:59:02 Q. You wrote that?
11:59:04 A. The last line says that,
11:59:09 yeah.
11:59:09 MS. MEADUS: Sorry, can we have
11:59:10 this marked as an exhibit?
11:59:12 THE COMMISSIONER: Yes, we can.
11:59:13 Is that Exhibit 114?
11:59:15 THE REGISTRAR: That's right.
11:59:16 THE COMMISSIONER: All right,
11:59:17 Exhibit 114, and it is Document
11:59:24 Number 71441, and it is a Form
11:59:26 3, Coroners Investigation
11:59:27 Statement by Dr. Urbantke.
11:59:26 EXHIBIT NO. 114: Form 3,
11:59:26 Coroners Investigation Statement
11:59:27 by Dr. Urbantke, Document 71441.
11:59:27 BY MS. MEADUS:
11:59:29 Q. And so when you flip over to
11:59:31 page 2, at that time, you reviewed the death
11:59:36 register, and you had some issues with the
11:59:39 death register.
11:59:40 And I just wanted to just
11:59:42 confirm that you would have written this in
11:59:46 this document; is that correct?
11:59:46 A. Yeah.
11:59:49 Q. And you found that there was
11:59:50 a problem with incompletely filled out number
11:59:53 of causes of death; is that correct?
11:59:56 A. That's what's written.
11:59:59 Q. Okay. And it says the staff
12:00:00 would have been directed to have this completed
12:00:02 and provide a copy for review when done.

12:00:04 So you would have requested -- this seems to indicate you would have requested them to complete the document properly and then return it to you so that you could review it again; is that correct?
12:00:13 A. Correct.
12:00:14 Q. Okay. And then you indicate that you, in fact, in this case, did find an accidental death due to a subdural hematoma from a fall. It was identified for which a coroner was not called; is that correct?
12:00:27 A. Correct.
12:00:27 Q. Okay. And then an investigation into this case was initiated; is that correct?
12:00:33 So this was a case where the threshold death -- you did go in, and you, in fact, did find an issue and did start another coroners investigation; is that correct?
12:00:41 A. It appears so.
12:00:43 Q. Appears so. And whether you did that or another coroner did that --
12:00:47 A. I'm not sure.
12:00:48 Q. You're not sure. Okay. Thank you.
12:00:50 And I just have one final question with respect to Ms. Pickering. You had notes. You indicate you take a lot of notes. Would you have taken notes of any call from Dr. George if he had called you to discuss this matter?
12:01:08 A. What notes do you --

12:01:14 Q. You had indicated that you would be pleased to speak to the coroner who was called on the case of Ms. Pickering?
12:01:23 A. Yes.
12:01:23 Q. Would you keep notes of that conversation?
12:01:25 A. Not that because I -- it was like an -- I'm not available because of the conflict of interest, so I wouldn't keep notes of that.
12:01:33 Q. But if Dr. George who was assigned to the case had called you to discuss the matter of your seeing Ms. Pickering in the emergency room and the issue around her hypoglycemia, would you have kept notes somewhere of that conversation?
12:01:46 A. Not necessarily.
12:01:48 Q. Not necessarily. Okay.
12:01:50 MS. MEADUS: Thank you. Those are my questions.
12:01:50 THE COMMISSIONER: Thank you, Ms. Meadus.
12:02:07 MS. ROBINSON: I see there's no further cross-examination, so Ms. Bambers on behalf of the Province in reexamination.
12:02:11 THE COMMISSIONER: Thank you very much.
12:02:13 RE-EXAMINATION BY MS. BAMBERS:
12:02:13 Q. Dr. Urbantke, you were asked about whether you ever had occasion to report a case of abuse or neglect to the Ministry of

Health, and I don't think a foundational question was asked.

Do you ever recall investigating a case that involved abuse or neglect of a patient that you can recall or a resident that you can recall?

A. Not that I recall.

MS. BAMBERS: Thank you.

THE COMMISSIONER: Thank you.

MS. ROBINSON: And I just have one topic I'd like to review with you, Dr. Urbantke, in reexamination.

RE-EXAMINATION BY MS. ROBINSON:

Q. You'll recall Mr. Scott, on behalf of one of the family groups, was asking you questions about what he called "the threshold decision making" when you receive a call from dispatch, and you're making a determination about whether or not to commence a death investigation. Do you recall Mr. Scott asking you questions of that nature?

A. Yes.

Q. And he was asking you a particular line of questioning about in the context of a death in a long-term care home, what documents you would have in front of you when evaluating whether or not to take that case as a coroners case. Do you remember those questions?

A. Yes.

Q. And he had asked you whether

12:03:52 you would have access to the long-term care
12:03:58 home records when making that decision. Do you
12:03:59 recall that question?
12:03:59 A. Yes.
12:03:59 Q. And I just want to confirm
12:04:01 for the purposes of the record what, if any,
12:04:04 medical records you will have in front of you
12:04:06 or have access to when you're making that
12:04:08 determination.
12:04:10 A. Potentially, I could have
12:04:14 hospital records or access to hospital records.
12:04:17 Q. Are there any other types of
12:04:19 medical records you may have available to you
12:04:20 when you're making that determination?
12:04:22 A. Unless I'm going into a
12:04:27 place, no.
12:04:29 MS. ROBINSON: Thank you,
12:04:29 Dr. Urbantke. Those are my
12:04:31 questions for you.
12:04:32 MS. FRASER: It would be
12:04:33 helpful, Madam Commissioner --
12:04:34 and I don't know if my voice is
12:04:37 being picked up because I know
12:04:39 we need to speak from -- okay.
12:04:40 It would be helpful, Madam
12:04:41 Commissioner, to know in terms
12:04:44 of that access -- the question
12:04:45 is access, and I think it's
12:04:47 important that we understand
12:04:49 authority in the context of
12:04:51 access and what Dr. Urbantke's
12:04:55 understanding of that might be.

12:04:57 So that's why I rise.
12:04:58 THE COMMISSIONER: I understand
12:05:05 where that question is coming
12:05:07 from certainly, Ms. Fraser.
12:05:09 What's your position on that?
12:05:12 MS. ROBINSON: I'm content to
12:05:13 ask the question if you believe,
12:05:17 Madam Commissioner, that it
12:05:18 would be of assistance to you.
12:05:20 THE COMMISSIONER: I think you
12:05:21 should talk to Ms. Fraser for a
12:05:23 moment and make sure that you
12:05:23 understand what her concern is
12:05:25 so that you phrase the questions
12:05:26 in a way that meets it.
12:05:29 MS. FRASER: Thank you.
12:05:40 MR. SCOTT: Commissioner, would
12:05:41 it be appropriate if I spoke
12:05:43 with counsel as well? My
12:05:46 recollection is I think I did
12:05:48 ask that question.
12:05:49 THE COMMISSIONER: I will hear
12:05:51 you on this. I don't want to
12:05:53 disrupt that. Let them have
12:05:55 that conversation, and then
12:05:57 we'll have a discussion
12:05:57 ourselves about what we need to
12:05:59 do to deal with this properly.
12:05:59 MR. SCOTT: Thank you.
12:06:20 THE COMMISSIONER: Before you
12:06:21 put your questions, can you
12:06:22 please tell me what manner of

12:06:24 questions you're going to put
12:06:26 and why, because Mr. Scott has
12:06:29 some concern about it.
12:06:31 So just hear the general
12:06:33 tenor of what it is that you're
12:06:34 going to clarify with this
12:06:36 witness.
12:06:37 MS. ROBINSON: Certainly. And I
12:06:38 didn't hear Mr. Scott's concern.
12:06:39 THE COMMISSIONER: No, that's
12:06:39 right, and I didn't either. He
12:06:41 just told me the nature of it,
12:06:42 and I put it on hold until you
12:06:44 had your conversation.
12:06:44 So if you can just tell us
12:06:47 the area that you're going to
12:06:49 explore with Dr. Urbantke, I
12:06:50 would appreciate that.
12:06:50 MS. ROBINSON: As I understand,
12:06:52 Ms. Fraser would like -- and
12:06:55 I think it's appropriate for me
12:06:56 to ask one additional question
12:07:00 in respect of Dr. Urbantke's
12:07:01 understanding of her authority
12:07:01 to access hospital medical
12:07:03 records when making that
12:07:05 determination about whether or
12:07:08 not to accept a case as a death
12:07:10 investigation.
12:07:10 THE COMMISSIONER: All right.
12:07:13 Mr. Scott?
12:07:15 MR. SCOTT: I believe that I had

12:07:16 asked Dr. Urbantke about what
12:07:18 medical records she can -- or
12:07:22 does access before she makes a
12:07:24 decision.
12:07:25 I don't believe she gave the
12:07:26 answer that she accesses any
12:07:28 medical records from the
12:07:30 hospital. That's my
12:07:33 recollection of her evidence.
12:07:34 THE COMMISSIONER: I'll tell you
12:07:36 what we'll do. I think we
12:07:37 should clarify this aspect of
12:07:39 her testimony, and if necessary,
12:07:41 if you feel you've been
12:07:42 prejudiced or whatever, then
12:07:44 we'll sort that out.
12:07:47 I think part of the problem
12:07:48 here is that terminology is
12:07:51 being used in an inconsistent
12:07:58 fashion.
12:07:58 So are we all agreed that
12:08:01 right now, we're discussing the
12:08:05 documents that Dr. Urbantke
12:08:08 would consider at the point in
12:08:14 which she's deciding whether or
12:08:17 not a death investigation should
12:08:18 be undertaken?
12:08:19 So it's not during the death
12:08:21 investigation. She's accepted a
12:08:24 call from central dispatch.
12:08:28 She's agreed that she will
12:08:29 accept the case.

12:08:30 She's now considering whether
12:08:31 or not to exercise her
12:08:32 discretion and -- or her power
12:08:36 to determine whether to conduct
12:08:37 a death investigation.
12:08:39 Are we all on the same page?
12:08:42 MS. ROBINSON: That's the page
12:08:43 I'm on, Commissioner.
12:08:44 MR. SCOTT: That's the page I'm
12:08:45 on as well, Commissioner.
12:08:47 MS. FRASER: Me as well.
12:08:48 Thank you.
12:08:48 THE COMMISSIONER: Okay. And
12:08:49 now we're talking specifically
12:08:50 about a case that she's been
12:08:53 contacted, and the death has
12:08:54 occurred in a long-term care
12:08:57 home of a resident; correct?
12:09:01 All right. And the question
12:09:02 is what documents she
12:09:04 understands she has the
12:09:06 authority to look at as well as
12:09:08 what documents she would, in her
12:09:12 general practice, look at;
12:09:14 correct?
12:09:15 MS. ROBINSON: I think we'd only
12:09:16 ask the latter question, and
12:09:18 Ms. Fraser is requesting the
12:09:19 former question be put to the
12:09:22 witness.
12:09:22 THE COMMISSIONER: What her
12:09:22 understanding is of her legal

12:09:24 right as to what documents she
12:09:26 could see.
12:09:27 MS. FRASER: Precisely.
12:09:28 Thank you, Madam Commissioner.
12:09:30 THE COMMISSIONER: All right.
12:09:30 And, Mr. Scott, you're okay with
12:09:32 this so far?
12:09:35 MR. SCOTT: Yes.
12:09:35 THE COMMISSIONER: All right.
12:09:36 And so please do it that way.
12:09:38 Do it that carefully. Set it
12:09:40 exactly the way -- well, I'll
12:09:42 set it, and then you ask the
12:09:44 question. Save us all some time
12:09:47 here.
12:09:47 THE WITNESS: I'm getting
12:09:48 confused too.
12:09:49 THE COMMISSIONER: So dispatch
12:09:50 has called you and asked you,
12:09:53 "Would you accept this as a
12:09:54 case?" And you've said, "Yes, I
12:09:56 will."
12:09:56 THE WITNESS: Okay.
12:09:56 THE COMMISSIONER: And you
12:09:56 understand that the death is of
12:09:57 a resident in a long-term care
12:10:02 facility. And the question
12:10:03 is -- there's two parts to the
12:10:05 question, and you'll hear
12:10:07 counsel -- she'll put it, but
12:10:09 one thing is, "Well, would it
12:10:10 have been your practice to look

12:10:11 1 at what medical documentation?"
12:10:13 2 And I would appreciate if you
12:10:15 3 would be careful about in the
12:10:16 4 home, not in the home.
12:10:16 5 THE WITNESS: Okay.
12:10:18 6 THE COMMISSIONER: And then also
12:10:19 7 what do you believe your legal
12:10:22 8 authority is, which documents
12:10:24 9 you believe -- not my question.
12:10:27 10 I'm setting the stage. The
12:10:28 11 counsel is going to set it up.
12:10:30 12 What you believe you have the
12:10:32 13 legal authority to look at at
12:10:34 14 that point before the death
12:10:34 15 investigation is undertaken.
12:10:38 16 You're only making a
12:10:38 17 determination whether or not to
12:10:39 18 set it up.
12:10:40 19 THE WITNESS: Okay.
12:10:41 20 THE COMMISSIONER: Did I set the
12:10:42 21 stage for everybody fairly?
12:10:46 22 Good. Okay. Go ahead.
12:10:46 23 MS. ROBINSON: I may ask one
12:10:46 24 additional question. I think
12:10:47 25 it's a factual one, which may
12:10:50 26 assist in understanding the
12:10:52 27 answer.
12:10:52 28 THE COMMISSIONER: Anything you
12:10:53 29 want, but those are the specific
12:10:55 30 areas that everybody wants to
12:10:57 31 have clear in their mind.
12:10:57 32 FURTHER RE-EXAMINATION BY

MS. ROBINSON:

Q. So as the Commissioner has indicated, I'm going to be asking you questions in the context of when you received a call from dispatch, you're available to consider the case, and you're undertaking that process of whether or not a case should be accepted as a coroners investigation.

A. Okay.

Q. My first question is as a practical matter, what records would you theoretically have access to when you're making that assessment in a long-term care home context?

A. So I would have -- so no access to the records at any long-term care facility that I've covered in the past. I would theoretically have access to hospital records.

Q. And why is that?

A. Because I work at the local hospital, and many of them are electronic now, and there's ability, if I'm in the hospital, access to them or, if I'm at home, remotely access them.

Q. Then in the context of a death that's reported to you in a long-term care home, what records would you theoretically access when making that determination as to whether or not to accept a case for death investigation?

A. I could theoretically

potentially access the hospital records.

MS. ROBINSON: And if that is clear for the Commissioner, I'll move on to the second part of the question, unless there are any follow-up about the access to records.

THE COMMISSIONER: Are you okay, Mr. Scott? You look very uncomfortable.

MR. SCOTT: Well, just that it's theoretical. I'd like to know if the witness accesses the hospital records.

MS. ROBINSON: Certainly.

THE COMMISSIONER: All right.

BY MS. ROBINSON:

Q. And, Dr. Urbantke, in your practice, if you are considering whether or not to investigate a death in a long-term care home, is it your practice to access any records when you're making that decision?

A. I can't say it's 100 percent. I would expect that I have accessed them in the past, but I can't say one way or the other for sure.

MR. SCOTT: That's fine.

BY MS. ROBINSON:

Q. And, Dr. Urbantke, do you have an understanding or what is your understanding of your legal authority to access medical records when you're in that

12:13:32 1 decision-making stage?
12:13:33 2 A. I have a better understanding
12:13:38 3 now because of this process. I access them to
12:13:46 4 help me make a good decision, but it's -- I
12:13:50 5 have a better understanding that it probably --
12:13:52 6 I don't have the complete authority to access
12:13:56 7 them. That's my understanding now through
12:13:59 8 this -- going through this process.
12:14:06 9 MR. GOLDEN: Well, Commissioner,
12:14:06 10 now I have a confusion because
12:14:08 11 the witness was asked twice in
12:14:10 12 this area, and twice she said --
12:14:12 13 she said that she didn't have
12:14:16 14 access to the facility records
12:14:18 15 unless she went to the facility.
12:14:19 16 And so that aspect is now
12:14:21 17 confused.
12:14:22 18 So I think in fairness, we
12:14:24 19 need to know whether prior to
12:14:27 20 being educated on -- in relation
12:14:30 21 to giving evidence today, the
12:14:31 22 witness appears to have
12:14:33 23 suggested that she would have
12:14:35 24 access to the records if she
12:14:37 25 chose to go to the long-term
12:14:39 26 care facility. I think we need
12:14:40 27 to make sure that we're clear on
12:14:43 28 that.
12:14:45 29 MS. ROBINSON: I can attempt to
12:14:47 30 clarify that.
12:14:47 31 THE COMMISSIONER: All right.
12:14:48 32 MS. MEADUS: I hate to stand;

however, and I believe there was testimony this morning when she went through some of the death records, she was looking at the older death records, I believe she indicated that she would look at the charts as well, and those would be ones that would be not under investigation at the time. So perhaps we can clarify that.

THE COMMISSIONER: Sorry, that was in respect of a threshold case, though; right? So she'd accepted it.

MS. MEADUS: My understanding was that she indicated that she looked at the threshold deaths, but if there were the previous nine deaths, she might look at the charts in those ones.

THE COMMISSIONER: Right, but she's accepted for -- it's a threshold case, so she's already investigating. It's not a decision whether --

MS. MEADUS: Threshold case, but not the other nine deaths.

THE COMMISSIONER: Okay. I understand exactly the same way. I don't think there's a confusion.

12:15:34 1 If she accepted to serve as
12:15:38 2 the local coroner on a threshold
12:15:40 3 case as -- so she's now
12:15:43 4 undertaking a death
12:15:44 5 investigation because it's a
12:15:45 6 threshold case, at that point,
12:15:47 7 she would look at the death
12:15:49 8 registry, and she would look at
12:15:52 9 the -- in general, her practice
12:15:53 10 was to look at the prior nine
12:15:55 11 cases and medical records on it.
12:15:58 12 Is that your question, that that
12:16:00 13 was --
12:16:02 14 MS. MEADUS: Well, my question
12:16:02 15 is -- my understanding is when
12:16:04 16 she goes to look at the
12:16:06 17 threshold death case, she's
12:16:09 18 taking the threshold death case
12:16:10 19 on, so that one she has access
12:16:12 20 to.
12:16:12 21 The question is is she also
12:16:13 22 looking at the others? My
12:16:13 23 understanding is she's -- in
12:16:14 24 threshold death cases, she looks
12:16:16 25 at the register.
12:16:16 26 THE COMMISSIONER: Right.
12:16:17 27 MS. MEADUS: And it's not clear
12:16:19 28 that -- about what her authority
12:16:21 29 to access the other medical
12:16:22 30 records is.
12:16:24 31 THE COMMISSIONER: I thought
12:16:24 32 your testimony was that you

12:16:26 didn't. You took a threshold
12:16:29 case when that was in -- the
12:16:34 practice that the tenth case, so
12:16:36 it was a threshold case, so you
12:16:40 knew you had to undertake a
12:16:41 death investigation.
12:16:41 Because it was a threshold,
12:16:42 you would go in. You would look
12:16:44 at the death registry. You
12:16:45 would look at the information on
12:16:46 it.
12:16:47 I did not hear you say -- but
12:16:50 I may be wrong. I did not hear
12:16:51 you say that you looked at the
12:16:53 underlying medical records for
12:16:54 those prior nine deaths.
12:16:56 THE WITNESS: I would say in
12:17:02 general, I don't. I don't
12:17:05 recall my specific answer this
12:17:06 morning.
12:17:09 I guess my understanding is
12:17:10 since I'm investigating as a
12:17:15 threshold death, those prior
12:17:17 nine sort of would fall under,
12:17:19 and if I had more questions and
12:17:21 wanted to go to the medical
12:17:22 records, that it would sort of
12:17:24 fall under the threshold -- the
12:17:25 umbrella of a threshold case.
12:17:29 THE COMMISSIONER: All right.
12:17:29 So there's sort of a
12:17:30 combination, but I'm going to

12:17:32 tell you what I hear you say.
12:17:32 THE WITNESS: Okay.
12:17:33 THE COMMISSIONER: Of course,
12:17:34 it's difficult because time has
12:17:35 passed, but at the time that you
12:17:37 would have been investigating
12:17:40 threshold deaths, you would have
12:17:41 started by looking at the death
12:17:44 registry for the prior people?
12:17:46 THE WITNESS: Yeah.
12:17:46 THE COMMISSIONER: And you
12:17:47 understood your authority and
12:17:48 you may have engaged that,
12:17:51 exercised it if you felt
12:17:56 necessary when you looked at the
12:17:58 prior nine deaths; is that
12:17:59 correct?
12:17:59 THE WITNESS: To look at those
12:18:00 medical records if I felt
12:18:02 necessary.
12:18:02 THE COMMISSIONER: Right. Okay.
12:18:03 So let me start with you,
12:18:04 Ms. Meadus. Any problems?
12:18:06 MS. MEADUS: No, that's fine.
12:18:08 THE COMMISSIONER: All right.
12:18:08 And if I have done anything to
12:18:09 upset you, you can clarify it in
12:18:13 reexamination.
12:18:15 We're not in a court even
12:18:17 though we're in a courtroom. We
12:18:18 just want to make sure we all
12:18:22 understand correctly.

So unless there's any problems with that, I think we can lay that piece to bed. And now what's left?

MS. ROBINSON: I understand Mr. Golden had a question that he wanted clarified, and I think I could do that in a quick manner.

THE COMMISSIONER: All right. Go ahead.

BY MS. ROBINSON:

Q. I understand Mr. Golden had a question about whether you would be accessing the long-term care facility's records, again, in this context of making a decision whether or not to accept a case.

And my question for you is would you ever attend at a long-term care residence before you had made a decision about whether or not to accept a case for death investigation?

A. Usually, if I'm attending, I've decided to take it on as a case.

Q. Okay.

MS. ROBINSON: I have no further questions in reexam.

MS. FRASER: Thank you. And I'm sorry I rose, Madam Commissioner, but we lose the opportunity once the witness is gone.

THE COMMISSIONER: There's no

12:19:26 apologies at all. Everybody is
12:19:26 best served by us all having a
12:19:26 shared and proper understanding.
12:19:29 All right. So are we
12:19:30 finished, then, all the
12:19:32 questioning with this?
12:19:34 MS. ROBINSON: That's correct.
12:19:34 THE COMMISSIONER: Thank you
12:19:35 very much, Dr. Urbantke.
12:19:36 THE WITNESS: Thank you.
12:19:36 THE COMMISSIONER: And we
12:19:37 appreciate you coming.
12:19:52 MS. JONES: Commissioner,
12:19:53 Dr. Urbantke was our final
12:19:55 witness for today. We will have
12:19:58 our next witness, Dr. Pollanen,
12:20:00 available on Monday morning.
12:20:01 THE COMMISSIONER: All right.
12:20:03 Thank you so much. Well, record
12:20:06 this is for us as a group.
12:20:08 Thank you very much for all your
12:20:10 hard work and for all the
12:20:12 cooperation as always. I will
12:20:14 see everyone on Monday.
12:20:17 Oh, thankfully, the CSO will
12:20:19 get after me if I don't do this.
12:20:22 They're going to clean the room,
12:20:24 so we have to take everything
12:20:26 out. Thank you.
12:20:27 THE REGISTRAR: This Public
12:20:28 Inquiry is adjourned until
12:20:30 Monday at 9:30 a.m.

12:20:32 -- PROCEEDINGS ADJOURNED AT 12:20 P.M. --

REPORTER'S CERTIFICATE

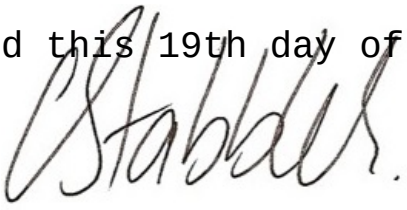
I, CARISSA STABBLER, Court Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

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

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 19th day of July 2018.



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