In the Matter Of:

The Long-Term Care Homes Public Inquiry

DAY 2 / VOL 2

June 06, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 2/Volume 2 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 6th day of June, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

REPORTED BY: Deana Santedicola, CSR, CRR, RPR

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

Mark Zigler, Esq., & Elizabeth Hewitt, Esq., & Rebecca Jones, Esq., & Megan Stephens, Esq., & Lara Kinkartz, Esq.,	Commission Counsel
Jared B. Schwartz, Esq.,	AdvantAge Ontario
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
Mark Sandler, Esq., & Megan Schwartzentruber, Esq.	College of Nurses
Paul H. Scott, Esq.,	Jon Matheson, Pat Houde, Beverly Bertram

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

Lisa Corrente, Esq.,	Jarlette Health Services, Meadow Park (London) Inc. o/a Meadow Park London Long-Term Care
Alex Van Kralingen, Esq., & Mark Repath, Esq., & Katherine Chau, 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
Darrell Kloeze, Esq., & Judith Parker, Esq.,	Her Majesty the Queen in Right of Ontario
Kate Hughes, Esq., & Nicole Butt, Esq.,	Ontario Nurses Association

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

Lauren Binhammer, Esq.,	Registered Nurses' Association of Ontario
Jennifer L. McAleer, Esq., & Rachel Laurion, Esq.,	Revera Long-Term Care Inc.
Shaun Singh, Esq.,	Registered Practical Nurses Association

ALSO PRESENT:

Dr. Fred Mather,	Ontario Long-Term Care Clinicians

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09:13:43 1 -- Upon commencing at 9:32 a.m.
09:25:12 2
09:33:20 3 THE COMMISSIONER: Good morning,
09:33:24 4 Ms. Hewitt, are you ready to go?
09:33:27 5 MS. HEWITT: Yes, Commissioner,
09:33:28 6 I'll just clean up one thing
09:33:29 7 that happened yesterday
09:33:30 8 afternoon before we get into the
09:33:31 9 witness testimony today.
09:33:32 10 You'll recall that yesterday I
09:33:35 11 was going through the early
09:33:36 12 stages of Elizabeth Wettlaufer's
09:33:39 13 career, her career before 2007
09:33:41 14 when she joined Caressant Care.
09:33:43 15 One of the matters I was dealing
09:33:44 16 with was the issue that arose at
09:33:46 17 Geraldton District Hospital, her
09:33:48 18 termination from that hospital
09:33:49 19 and the subsequent report to the
09:33:53 20 College of Nurses, and the
09:33:56 21 decision on consent that was
09:33:58 22 sent to Elizabeth Wettlaufer's
09:34:02 23 employer. Under the terms and
09:34:03 24 conditions of that consent, she
09:34:06 25 had to release it to her
09:34:07 26 employer.
09:34:08 27 And just to refresh your memory,
09:34:09 28 we don't need to call it up, but
09:34:11 29 that is document 36808, and in
09:34:15 30 that respect, I went through the
09:34:19 31 number of conditions that were
09:34:20 32 placed upon Elizabeth Wettlaufer

09:34:23 at that time: not abuse any
09:34:25 substance, advise her current
09:34:28 employer of the decision, advise
09:34:29 future employers of the
09:34:31 decision, continue under care,
09:34:33 et cetera.
09:34:34 And then I referenced the
09:34:36 provision that indicated that if
09:34:38 she complied with those
09:34:39 conditions for a year, then she
09:34:43 would have satisfied the
09:34:44 monitoring conditions.
09:34:46 So it indicates at paragraph 13:
09:34:49 "The Conditions shall remain in
09:34:51 force for a period of one year
09:34:52 from the date of this Decision
09:34:54 and if fully complied with shall
09:34:56 automatically be of no further
09:34:58 force and effect [...]"
09:34:59 I also believe that I indicated
09:35:01 to the Commissioner that that
09:35:02 did occur, that after that year
09:35:04 of those conditions, they were
09:35:08 lifted. It was determined that
09:35:10 she had complied with those
09:35:11 conditions.
09:35:11 But at the end of the day,
09:35:13 Mr. Sandler rose and asked a
09:35:15 procedural question as to
09:35:18 information that is in the
09:35:20 College's portion, their
09:35:25 Overview Report, that would not

09:35:27 1 be contained within the
09:35:29 2 facilities report, because that
09:35:30 3 information wouldn't have been
09:35:31 4 disclosed to the facilities.
09:35:32 5 We have spoken overnight and a
09:35:34 6 resolution in respect of this
09:35:35 7 particular matter, number one,
09:35:37 8 we know the College of Nurses
09:35:38 9 has their Overview Report. We
09:35:40 10 know they will have their
09:35:42 11 opportunity during their week to
09:35:46 12 speak to it.
09:35:47 13 But I'm just going to refer you
09:35:48 14 to some paragraphs for both you
09:35:51 15 and the public's sake to put
09:35:52 16 some context in respect to this
09:35:54 17 matter that are contained in the
09:35:59 18 Overview Report of the College
09:36:01 19 of Nurses.
09:36:01 20 And that is simply paragraph 19
09:36:08 21 simply talks about the fact that
09:36:09 22 she was informed that this
09:36:12 23 matter was referred to the
09:36:15 24 executive -- or to the Board of
09:36:17 25 Inquiry to determine her
09:36:19 26 incapacity.
09:36:19 27 And paragraphs 21 through 26,
09:36:26 28 which talks about the steps that
09:36:27 29 were taken by the College before
09:36:30 30 they imposed the restrictions in
09:36:32 31 1997. And in particular, I have
09:36:35 32 agreed with Mr. Sandler I'll

09:36:38 read the following two portions
09:36:39 into the record at this time.
09:36:41 Paragraph 24 of the College of
09:36:46 Nurses Overview Report
09:36:47 identifies:
09:36:48 "Following a telephone
09:36:50 conversation with counsel to
09:36:51 Elizabeth Wettlaufer, the
09:36:53 College of Nurses writes to
09:36:54 counsel enclosing a report by
09:36:56 Dr. Cunningham and referring to
09:36:58 an upcoming appointment with
09:37:01 psychiatrist Dr. Ross.
09:37:02 Dr. Cunningham's report provided
09:37:04 that he had assessed Elizabeth
09:37:06 Wettlaufer on June 14th, 1996,
09:37:08 and referred to having reviewed
09:37:10 [her] records 'from Northern
09:37:12 Ontario'.
09:37:13 Dr. Cunningham concluded that
09:37:15 while Elizabeth Wettlaufer was
09:37:17 an 'incapacitated Nurse under
09:37:20 the Act', she has 'since
09:37:22 December 1995 made significant
09:37:24 changes in her lifestyle and is
09:37:27 demonstrably in recovery'. He
09:37:30 stated that she required no
09:37:31 further assessment or treatment
09:37:32 at that time, but should
09:37:33 continue with the Health
09:37:36 Professional Support Group with
09:37:37 reports going back to the

09:37:38 College of Nurses from
09:37:40 Dr. Judson. He did not feel
09:37:41 that there were further narcotic
09:37:43 concerns and he felt that other
09:37:45 than urine monitoring, there
09:37:46 should be no further assessment
09:37:47 or management of that issue."
09:37:50 And then at paragraph 25, a
09:37:53 report from Dr. Ross:
09:37:55 "In his report, Dr. Ross
09:37:57 referred to the reports of
09:37:59 Dr. Cunningham and Brenda
09:38:00 Abraham, a caseworker at North
09:38:03 of Superior Programs. Dr. Ross
09:38:04 concluded that Elizabeth
09:38:06 Wettlaufer suffered from a
09:38:07 'Major Depressive Disorder
09:38:10 Single Episode of moderate
09:38:13 severity'. He also concluded
09:38:14 that 'Ms. Parker's occupational
09:38:16 difficulties arose in the
09:38:17 context of a mental disorder
09:38:19 which interfered with her
09:38:21 function,' and that 'Ms. Parker
09:38:22 is no longer ill.[...]'."
09:38:26 And you will recall, I'll just
09:38:28 stop for a minute there,
09:38:29 Commissioner, Parker is
09:38:30 Elizabeth Wettlaufer's maiden
09:38:32 name, and for the benefit of the
09:38:33 public.
09:38:34 "'Ms. Parker is no longer ill

09:38:36 from a psychiatric standpoint'
09:38:38 and as a result 'no active
09:38:40 treatment is required' and a
09:38:41 'return to work is realistic and
09:38:42 safe in my view.'"
09:38:46 It goes on to paragraph 26, and
09:38:51 paragraph 28, which talks
09:38:54 about -- again, talks about the
09:38:57 conditions.
09:38:57 Paragraph 34 and paragraph 36
09:39:00 and 37 all relate to the steps
09:39:04 that were taken before the
09:39:06 conditions were imposed upon Ms.
09:39:10 Wettlaufer, which were then
09:39:11 disclosed to her current
09:39:12 employer at the time, Christian
09:39:14 Horizons.
09:39:14 He also requested that I refer
09:39:17 you to paragraphs 39 and 40, and
09:39:21 the last paragraph which deals
09:39:23 with the lifting of the
09:39:25 conditions in May 1998:
09:39:30 "The College of Nurses speaks to
09:39:32 Dr. Tam, who provides an update
09:39:35 on Elizabeth Wettlaufer,
09:39:36 indicating that she is doing
09:39:37 fine and 'in good health.' Dr.
09:39:40 Tam stated that he has 'no
09:39:41 concerns' with respect to a
09:39:43 'possible relapse'."
09:39:46 So my understanding, based on
09:39:48 the requests from Mr. Sandler,

09:39:50 is that that satisfies the
09:39:52 concern that he had that the
09:39:57 perspective of the facilities
09:40:00 wouldn't have touched upon those
09:40:01 particular items.
09:40:03 THE COMMISSIONER: Thank you
09:40:03 very much.
09:40:05 MR. SANDLER: Yes, I am grateful
09:40:06 to my friend for that.
09:40:07 THE COMMISSIONER: Thank you.
09:40:08 And just so we are all clear, I
09:40:11 don't think we will have very
09:40:13 many of these issues arising
09:40:15 again, because we'll be largely
09:40:16 into witnesses, but if there are
09:40:20 read-ins and so on that cause
09:40:24 any concerns on the part of any
09:40:25 of the Participants, the
09:40:27 recommended process that I
09:40:28 suggested yesterday is that at
09:40:30 some appropriate break shortly
09:40:32 afterwards that the concerned
09:40:34 person would speak directly to
09:40:36 that investigator and see what
09:40:37 the proposed resolution was and
09:40:40 that if they couldn't come to
09:40:41 that resolution, that they would
09:40:43 see me in chambers. We have
09:40:45 such a limited amount of public
09:40:46 hearing time. That is probably
09:40:48 the most efficient method. So I
09:40:51 just thought I would make sure

everybody was clear about a proposed process.

All right, so I'm ready when you are with your first witness.

MS. HEWITT: Thank you, Commissioner. If I could call Ms. Brenda Van Quaethem to the stand.

BRENDA VAN QUAETHEM: SWORN.

THE COMMISSIONER: Good morning, Ms. Van Quaethem, thank you so much for coming to help us this morning. I appreciate that.

Go ahead, Counsel.

EXAMINATION IN-CHIEF BY MS. HEWITT:

Q. Before we start on any questionings this morning, Ms. Van Quaethem, I would like to put to you an affidavit dated June 4th, 2018. I believe Madam Clerk has a copy of that affidavit. It is document AFF1 on the database.

If I can just have you turn to the last page of your affidavit, and that is at the very beginning, Ms. Van Quaethem, and just identify that that is your signature?

A. Yes, it is.

Q. And you confirm that the contents of this affidavit are true?

A. Yes.

Q. Now, Commissioner, we do have two corrections to the affidavit to make that

were brought to my attention -- well, I found one last night.

One is paragraph 58, and we'll put this in context when we get to it, but I thought I would just correct it now. You don't need to go to paragraph 58. But it talks about Ms. Wettlaufer showing her co-worker a boil on her buttocks. That should say "groin area", at the very bottom of paragraph 58.

THE COMMISSIONER: Instead of "buttocks"?

MS. HEWITT: Correct.

THE COMMISSIONER: It should say "groin area"?

MS. HEWITT: Correct.

THE COMMISSIONER: Okay.

MS. HEWITT: And the second is simply a doc ID at paragraph 37. That doc ID should actually read 70956.

THE COMMISSIONER: So it is going to be LTCI0007 --

MS. HEWITT: 0956.

THE COMMISSIONER: 70956, thank you, yes.

BY MS. HEWITT:

Q. All right. Ms. Van Quaethem, before we start your career at Caressant Care, perhaps you can just provide the Commissioner with some background in terms of your education and employment before getting to Caressant Care?

09:45:04 A. Before Caressant Care, I worked as a nurse aide at a local nursing home. I took courses through Fanshaw and I -- payroll, Simply Accounting, Microsoft Office, took courses, and then I worked as an Administrator Assistant at that nursing home. I was asked by the owners to take the Long-Term Care Management course, which I did over a period of two years. And I worked at another facility, Cedarwood Village, which was owned by the same owners and I was the Acting Administrator there while I was taking my courses. And then I stayed on as Administrator there until the end of June 2009.

Q. Did you have any education to become a nurse's aide?

A. No, I had actually -- I was widowed and I remarried and my husband worked for his son in farming, and so there was nothing for me to do, so I phoned the nursing home in Tillsonburg to see what type of courses I would have to take to be a PSW.

And the Director of Care at that -- I think she was called the Director of Nursing. The Director of Nursing at that nursing home knew me and she said, Brenda, you did home dialysis for ten years with your husband. She says, you can look after people. She says, I know you can.

Q. Thank you, Ms. Van Quaethem. So as I understand it, you don't have a registered -- any Registered Nursing degree; is

09:47:05 1 that correct?
09:47:05 2 A. No, I do not.
09:47:06 3 Q. And prior to becoming an
09:47:08 4 Acting Administrator, you took an
09:47:10 5 administration course; is that correct?
09:47:13 6 A. Yes.
09:47:15 7 Q. And so was your first
09:47:18 8 full-time role as an Administrator at Caressant
09:47:21 9 Care?
09:47:21 10 A. No, Cedarwood Village.
09:47:24 11 Q. At Cedarwood Village?
09:47:26 12 A. Yes.
09:47:26 13 Q. All right. And you stayed
09:47:28 14 there for approximately two years?
09:47:33 15 A. Yeah, that is hard. My
09:47:34 16 timelines there are hard to figure out. I
09:47:37 17 think from 2005 I was there until 2009, and I
09:47:47 18 may not be correct on that because, like I
09:47:50 19 say --
09:47:50 20 Q. It was a long time ago.
09:47:52 21 A. It was a long time ago, yes.
09:47:53 22 Q. I understood that you worked
09:47:54 23 as an Acting Administrator, was that for a
09:47:58 24 period of approximately two years then?
09:47:59 25 A. While I was taking the
09:48:01 26 course, yes.
09:48:01 27 Q. All right.
09:48:02 28 A. I couldn't be called the
09:48:07 29 Administrator, so the owner was an
09:48:08 30 Administrator, and I was Acting Administrator
09:48:10 31 under his direction.
09:48:10 32 Q. All right, so you weren't the

09:48:12 sole --
09:48:12 A. No, no.
09:48:13 Q. -- Administrator within that
09:48:14 home. You also had the owner?
09:48:15 A. Yes, I had support, yes.
09:48:16 Q. All right, thank you. Now,
09:48:22 you have outlined in paragraphs 6 to 8, and you
09:48:26 don't have to turn to it right now, Madam
09:48:31 document person -- I'm sorry, what am I
09:48:34 supposed to call you? Amanda. That is much
09:48:38 better, Amanda. You don't have to turn to it
09:48:41 now, Amanda.
09:48:44 But, Ms. Van Quaethem, I know
09:48:47 you have outlined your duties as an
09:48:49 Administrator in those paragraphs, but perhaps
09:48:50 if you could just provide a brief description
09:48:52 of your role as Administrator at Caressant
09:48:55 Care?
09:48:56 A. Okay, but could you call me
09:48:58 Brenda?
09:48:59 Q. Sorry, could I call you
09:49:01 Brenda? Is that all right, Commissioner?
09:49:03 THE COMMISSIONER: That is fine.
09:49:05 BY MS. HEWITT:
09:49:05 Q. Certainly, Brenda.
09:49:06 A. Thank you. My role as
09:49:11 Administrator was to oversee the home,
09:49:14 reporting to head office, payroll duties,
09:49:21 reporting to the Ministry of Health, dealing
09:49:26 with Ministry of Labour, dealing with CCAC,
09:49:31 filling beds, overseeing the responsibilities
09:49:37 of the building's needs, getting quotes for

09:49:43 1 things that were required in the nursing home.
09:49:50 2 Oh, yeah, the list kind of goes on and on.
09:49:54 3 Q. Was it a busy job?
09:49:56 4 A. Extremely. There was -- we
09:50:01 5 had 163 residents in the nursing home. We had
09:50:05 6 100 residents in the retirement home. I was
09:50:08 7 not responsible for the retirement home other
09:50:11 8 than the building aspect of it. We had over
09:50:17 9 200 staff. Yes, it was very busy every day.
09:50:22 10 Q. I'm just going to go back
09:50:28 11 just a bit. The Ministry of Health that you
09:50:31 12 discuss, is that who we have been referring to
09:50:33 13 as the Ministry of Health and Long-Term Care?
09:50:36 14 A. Long-Term Care, yes.
09:50:38 15 Q. And the CCAC is the Community
09:50:40 16 Care Access Centre?
09:50:41 17 A. The Community Care Access
09:50:42 18 Centre, yes.
09:50:43 19 Q. We have heard that
09:50:48 20 Mrs. Crombez is going to testify within these
09:50:52 21 proceedings, and I understand that she was the
09:50:53 22 Director of Nursing?
09:50:54 23 A. Yes, she was.
09:50:55 24 Q. What was the difference
09:50:56 25 between your role as Administrator and her role
09:50:59 26 as Director of Nursing?
09:51:01 27 A. Her role was more direct to
09:51:06 28 nursing care of residents, with the management
09:51:14 29 of the nursing staff or the hiring of the
09:51:19 30 registered staff, the PSWs. Her role was
09:51:23 31 directly all nursing resident-related, where my
09:51:30 32 job had an oversight to that, but had other

09:51:34 duties as well.
09:51:35 Q. And would she be best placed
09:51:42 to speak to the medication management system,
09:51:45 the workings of that system and the handling of
09:51:48 insulin over yourself in terms of your
09:51:50 experience?
09:51:51 A. Absolutely, yes.
09:51:53 Q. Okay. So, Commissioner, we
09:51:56 have identified that we will be calling
09:51:59 Mrs. Crombez to deal with all of those specific
09:52:01 issues with respect to medication management
09:52:03 and the delivery of insulin.
09:52:06 So if I may, one of the other
09:52:09 issues that you identify in your affidavit is a
09:52:13 complicated issue, and I don't intend to get
09:52:15 into this issue very much, but the Ministry of
09:52:22 Health and Long-Term Care is involved in
09:52:23 funding, as I understand, the nursing home in
09:52:28 respect of nursing and personal care; is that
09:52:31 correct?
09:52:31 A. Yes.
09:52:31 MS. HEWITT: Now, we are going
09:52:34 to hear, Commissioner, from
09:52:37 nurses, from PSWs, from RPNs,
09:52:40 Registered Practical Nurses,
09:52:42 about the underlying part of
09:52:45 their work that they have to do
09:52:47 to translate information to the
09:52:49 home in order to get that
09:52:52 particular funding.
09:52:55 So I would just like to read
09:52:59 Brenda's, two portions of her

09:53:01 affidavit, which sets out a
09:53:03 complicated system and tries to
09:53:05 identify it at least in more
09:53:08 layman's terms, if I could?
09:53:10 THE COMMISSIONER: Yes.
09:53:11 BY MS. HEWITT:
09:53:11 Q. And those would be paragraphs
09:53:14 12 and 13, if we could have those paragraphs up
09:53:19 on the -- of the affidavit.
09:53:27 I am just going to read that,
09:53:51 and then I'll ask you some questions on that,
09:53:53 Brenda:
09:53:54 "While I was Administrator, we
09:53:57 also implemented the Resident
09:54:00 Assessment Instrument/Minimum
09:54:02 Data Set."
09:54:04 And it has an acronym there
09:54:07 which I believe is pronounced RAI/MDS?
09:54:11 A. Yes.
09:54:12 Q. "In long-term care the nurses
09:54:13 would complete care plans for
09:54:14 each of the residents. The
09:54:17 RAI/MDS system was an extension
09:54:19 of these care plans. It was a
09:54:20 computerized system which was
09:54:22 often difficult in the beginning
09:54:23 for the staff to negotiate. It
09:54:24 required quarterly assessments
09:54:25 of the residents, based on daily
09:54:27 charting and assessments by the
09:54:29 nursing staff and the PSW
09:54:30 staff."

09:54:31 1 And as I said, Commissioner, you
09:54:32 2 will hear about that from those
09:54:34 3 staff members.
09:54:34 4 "That information would be
09:54:36 5 reviewed by our RAI Coordinator,
09:54:38 6 inputted into the Canadian
09:54:39 7 Institute for Health Information
09:54:41 8 system and eventually translate
09:54:43 9 into Caressant Care's Case Mix
09:54:46 10 Index."
09:54:47 11 Which I understand is known in
09:54:48 12 the industry as CMI; am I correct, Brenda?
09:54:52 13 A. Yes.
09:54:52 14 Q. Okay.
09:54:53 15 "Our funding from the [Ministry
09:54:56 16 of Health and Long-Term Care]
09:54:56 17 would then be based on Caressant
09:54:57 18 Care's CMI. The Home would
09:54:59 19 receive funds from the [Ministry
09:55:05 20 of Health and Long-Term Care]
09:55:05 21 for, among others, nursing and
09:55:07 22 personal care, which we called
09:55:09 23 the 'Nursing and Personal Care
09:55:10 24 Envelope'. Those funds would be
09:55:12 25 used for staffing (including
09:55:14 26 Registered Nurses, Registered
09:55:16 27 Practical Nurses and Personal
09:55:19 28 Support Workers, as well as
09:55:20 29 training and certain authorized
09:55:22 30 equipment and supplies. The
09:55:23 31 CMI", or Case Mix Index, "is
09:55:25 32 annually adjusted based on the

09:55:27 acuity level of the residents."
09:55:33 So as I said, I know that is a
09:55:34 very short explanation of a very complicated
09:55:37 system for now, but I just have a couple of
09:55:42 questions for you.
09:55:44 You indicate that Caressant Care
09:55:46 would receive funds from the Ministry for the
09:55:48 nursing and personal care envelope; what do you
09:55:51 mean by the term "envelope"?
09:55:53 A. It was a system we referred
09:55:54 to, and the Ministry of Health actually
09:55:57 provided us with three envelopes and there was
09:56:00 one for nursing and personal care; there was
09:56:03 one for programs; and then there was another
09:56:06 envelope that was referred to as "other."
09:56:10 So anything to do with residents
09:56:15 and their personal care, some of the supplies
09:56:20 came from that envelope, like that set of
09:56:26 money.
09:56:26 Programming was more like for
09:56:28 the activities that we did with the residents.
09:56:35 And the other was -- I really
09:56:38 can't talk to that. That was more handled
09:56:41 through head office, but I think the homes were
09:56:45 provided with a per diem per resident per day
09:56:49 for funding for these types of, you know -- I
09:56:54 don't know if building upgrade came in there or
09:56:56 what, but any financing through the nursing
09:57:00 budget or through the program budget had to be
09:57:03 spent each year. If you didn't spend it, you
09:57:06 had to return it to the Ministry. If you went
09:57:09 over your budget, it would have to come out of

09:57:14 I guess through the owner's budget, I guess.
09:57:18 Q. All right, so when we talk
09:57:19 about envelope, it is a set of funds?
09:57:21 A. Yeah, it is a set of funds.
09:57:25 Q. So for nursing and personal
09:57:27 care, your affidavit indicates that that would
09:57:30 be used by the home I'm assuming for the
09:57:33 payroll, for staff, for benefits, et cetera?
09:57:36 A. Yes, right.
09:57:36 Q. And would you be able to use
09:57:41 the funds that you are given from the Ministry
09:57:43 in that envelope or set of funds for anything
09:57:46 other than what was authorized to be used in
09:57:48 that envelope? In other words, could you
09:57:51 transfer it to supplement some of the other
09:57:54 things that you were doing?
09:57:55 A. No, we had to use it -- it
09:57:59 was set. The regulations were set by the
09:58:02 Ministry on how you could use the funds.
09:58:04 Q. And would the Ministry also
09:58:05 monitor how you used those funds?
09:58:10 A. Yes, I believe so, but that
09:58:12 was done at year-end through our head office.
09:58:13 Q. So the head office would have
09:58:15 to report --
09:58:17 A. Yes.
09:58:17 Q. As I said, I don't have very
09:58:19 many questions, but the one item in paragraph
09:58:22 12 of your affidavit indicates that that fund,
09:58:28 those monies, are annually adjusted based on
09:58:31 the acuity level of residents. What do you
09:58:34 mean by "acuity level"?

09:58:36 A. What the residents' needs
09:58:42 require. Like one resident over another
09:58:45 resident could be -- require a lot more care, a
09:58:50 lot more supplies, so every resident is
09:59:00 identified. And I don't know the coding system
09:59:04 for it, but once we switched to RAI, I don't
09:59:08 even believe it was called CMI anymore, but
09:59:11 they were classified according to their needs
09:59:14 and that is how our funding was set out for
09:59:16 that.
09:59:17 Q. So the underlying
09:59:20 assessments, et cetera, would be done by the
09:59:22 direct care staff, the registered staff, and
09:59:24 would go up and would be coded, as you said,
09:59:27 and you didn't get involved in that, but the --
09:59:29 A. And also our PSWs did
09:59:31 charting and that would be identified in the
09:59:35 system then too on their care needs.
09:59:37 Q. All right. And so that would
09:59:39 go up, and then it would result in an acuity
09:59:44 level and your funding would be based on that?
09:59:46 A. Yes.
09:59:46 Q. Did you see a difference in
09:59:48 your experience, as you were at Caressant Care,
09:59:51 in the acuity level of residents over those
09:59:53 years?
09:59:54 A. Yes.
09:59:55 Q. And what was the difference?
09:59:58 What were you seeing?
09:59:59 A. In my years of working in
10:00:03 long-term care, I would say that residents
10:00:09 today that live in a retirement home are what I

10:00:15 1 first started working with; more residents
10:00:19 2 could walk with walkers, not as many required
10:00:22 3 the use of lifts.
10:00:27 4 Now, nursing homes are more for
10:00:29 5 the frail elderly. There has been more funding
10:00:33 6 to home care so people could remain in their
10:00:38 7 homes longer. And so in long-term care, over
10:00:44 8 the last years they are definitely more frail.
10:00:51 9 So many are -- you know, we have to use lifts
10:00:54 10 on them. Most are using walkers or
10:00:59 11 wheelchairs, not that many independent people.
10:01:01 12 Q. And so if a resident comes in
10:01:08 13 and needs to be transferred from bed to toilet,
10:01:12 14 from toilet to wheelchair, that level of care
10:01:19 15 would be assessed and that may impact, if those
10:01:22 16 residents -- if you had a number of those
10:01:24 17 residents, that may impact your acuity level
10:01:26 18 from year to year?
10:01:27 19 A. Yes.
10:01:28 20 Q. All right. So thank you for
10:01:37 21 explaining some of those items within your
10:01:39 22 affidavit.
10:01:40 23 I want to turn to the issue of
10:01:43 24 registered staff. Now, my understanding from
10:01:46 25 your career path is that you would have entered
10:01:51 26 Caressant Care after Elizabeth Wettlaufer was
10:01:53 27 already hired; correct?
10:01:54 28 A. Yes. I went there in July of
10:01:58 29 2009, and I believe she was hired in 2007.
10:02:05 30 Q. In general while you were
10:02:09 31 there, from 2009 to 2016, what was your
10:02:17 32 experience in the recruiting and retention of

10:02:18 Registered Nurses for the home?
10:02:19 A. Well, recruiting was very
10:02:27 difficult. Retention, we tried to keep who we
10:02:32 had because there was such a shortage of
10:02:36 Registered Nurses that we were short at all
10:02:44 times.
10:02:45 We applied to different programs
10:02:53 to recruit nursing staff, and there was some
10:03:00 initiatives by the Ministry of Health, late
10:03:05 career nursing. There was new grad programs.
10:03:09 There was guidelines around those programs, so
10:03:12 the new grad program, I don't believe that we
10:03:17 could meet the requirements of that program
10:03:21 because you could get a new grad to come in and
10:03:23 work with a Registered Nurse for a certain
10:03:27 period of time. There was extra funding given
10:03:30 for that. But then I think there was a
10:03:33 requirement that you could offer, once they did
10:03:38 the requirement, that they could be offered a
10:03:40 full-time position, and we didn't have
10:03:43 full-time positions to give to them and so we
10:03:46 couldn't apply to the program.
10:03:47 The Late Career Nursing Program,
10:03:50 we did activate that line of the program, and
10:04:00 so I think it was a nurse over 55 years old,
10:04:06 they would say they could enter into the Late
10:04:09 Career Program. We would apply. That nurse
10:04:12 could have extra -- or different duties than
10:04:15 their normal daily duties, so they could do
10:04:18 auditing, updating care plans, more desk type
10:04:22 work we would give them. And that would allow
10:04:25 their normal hours to be given to our part-time

staff, give our part-time staff more hours so, you know, that it was attractive to them to stay with us, because so often nurses would -- we had a lot of part-time staff and then they would work two jobs and you could lose them then to another facility if a full-time job came up in another facility if it didn't come up in ours.

So yeah, it was a constant battle to keep registered staff.

Q. And as I understand your testimony, you would -- where it was available and made sense for Caressant Care, you would take advantage of whatever programs were offered by the Ministry?

A. We would try, yes, we would try.

Q. Okay. And the difficulties in recruitment and retention, did you have any experience in terms of -- or opinion in terms of why is it difficult to recruit or retain Registered Nurses?

A. I think that, and this is my opinion, I believe that, you know, when someone decides to be a nurse, they picture themselves in a hospital setting. It seems like the new grads were going to hospitals. Long-term care maybe wasn't their first choice.

When we did have nurses that would apply and get hired, we had quite a few were shocked at how hard the work was in long-term care and didn't stay. Like, they

10:06:07 1 were like, we didn't know -- you know, I think
10:06:11 2 they thought -- they had a different vision of
10:06:13 3 a nursing home or a long-term care home than
10:06:15 4 what we really did look after, because we had
10:06:18 5 all types of care in our home.
10:06:22 6 There is a shortage of nurses I
10:06:27 7 believe still to this day in the field. They
10:06:34 8 are overworked. I am experiencing that right
10:06:41 9 now with my dad in the hospital and hearing the
10:06:44 10 nurses saying, yes, I'm working overtime again.
10:06:48 11 They can't find anybody. I just think it is
10:06:52 12 pretty well universal around here there is a
10:06:56 13 nursing shortage.
10:06:56 14 Q. So you are reflecting
10:06:58 15 hospital nursing shortages as well as --
10:07:00 16 A. Yes, as well, uhm-hmm, yes.
10:07:02 17 Q. In long-term care, in
10:07:05 18 Caressant Care, approximately how many
10:07:07 19 residents would a Registered Nurse be
10:07:10 20 responsible for on a daily basis?
10:07:11 21 A. In the nursing -- in the
10:07:14 22 long-term care?
10:07:15 23 Q. In Caressant Care at the time
10:07:16 24 that you were there; do you recall the
10:07:19 25 staffing?
10:07:19 26 A. It -- yeah, not clearly. It
10:07:22 27 has been a few years.
10:07:23 28 Q. We will have the actual
10:07:25 29 staffing levels coming through Mrs. Crombez.
10:07:31 30 A. Okay. There was more
10:07:36 31 registered staff on day shift, less on evenings
10:07:41 32 and then less at nights.

10:07:43 Day staff, I believe, was three
10:07:47 for 163 residents, afternoons I believe was 2,
10:07:55 and nights was 1.
10:07:57 Q. And that is speaking to a
10:07:59 Registered Nurse on --
10:08:00 A. Yes, a Registered Nurse.
10:08:02 There was RPNs along with that.
10:08:04 Q. And we will get the staffing
10:08:07 level through Ms. Crombez, but in my
10:08:11 understanding, and correct me if I'm wrong, is
10:08:14 that the regulations under the Long-Term Care
10:08:17 Homes Act require you to have a Registered
10:08:20 Nurse 24 hours a day for 7 days a week; is that
10:08:24 correct?
10:08:24 A. Oh, yes, that's correct. And
10:08:26 if you do not meet that standard, you have a
10:08:29 finding from the Ministry.
10:08:34 Q. And did that ever take place
10:08:36 at Caressant Care?
10:08:36 A. Yes, it did. I don't recall
10:08:38 what year, but we did have a finding for that.
10:08:44 And it was a night shift, and I think we
10:08:49 couldn't find an RN to -- one RN -- we were
10:08:54 short an RN for night shifts. One of the
10:08:57 afternoon girls could stay like till 2:00 in
10:09:01 the morning, but we couldn't cover from 2:00 in
10:09:04 the morning till 7:00 in the morning. And my
10:09:07 timelines might be wrong on this, but I believe
10:09:09 it was for four hours that we didn't have an
10:09:12 RN. But we did cover with two RPNs with my
10:09:15 Director of Nursing on call, but we did receive
10:09:18 a finding.

10:09:18 Q. So your testimony is you
10:09:24 would replace one RN for those four or five
10:09:27 hours with two RPNs and the Director of Nursing
10:09:30 on call, but that was still indicated to be
10:09:32 non-compliant?
10:09:33 A. Because the regulation was
10:09:35 that you have an RN in the building 24/7, and
10:09:37 we did not meet that regulation that time.
10:09:41 Q. Now, Elizabeth Wettlaufer, as
10:09:43 I understand it, came on board with Caressant
10:09:46 Care in 2007, and primarily, as I read the
10:09:51 evidence, worked evenings and nights; is that
10:09:54 your recollection as well?
10:09:55 A. Yes, when I was there, she
10:09:57 was primarily evenings and nights.
10:09:59 Q. All right. So she would
10:10:01 either be on evening shift, your recollection
10:10:03 is one of two Registered Nurses on staff, or if
10:10:08 it was a night shift, she would be the only
10:10:10 Registered Nurse on staff?
10:10:12 A. The registered -- yes, she
10:10:15 would have RPNs or an RPN with her.
10:10:18 Q. And what would -- if a
10:10:23 Registered Nurse is on night and that is the
10:10:24 only Registered Nurse on duty, what would her
10:10:27 duties at that point in time be?
10:10:29 A. She had a section of the home
10:10:32 to work and give out meds to, but she would
10:10:36 also oversee the remaining part of the home if
10:10:39 the RPN required assistance with, you know,
10:10:46 with a medical crisis, I would say.
10:10:49 Q. So if I understand your

10:10:52 1 testimony correctly, it wasn't as if the RN --
10:10:56 2 I believe they -- are they called the charge
10:11:00 3 nurse at night then if they are --
10:11:01 4 A. Yeah, she would be the charge
10:11:02 5 nurse.
10:11:03 6 Q. So the charge nurse would not
10:11:05 7 simply be there to respond to issues within the
10:11:07 8 building, but she would actually have her own
10:11:10 9 set of residents to deal with --
10:11:13 10 A. Yes, she would have her
10:11:15 11 residents and be in charge of like making sure
10:11:17 12 the doors were secured at night, yes. She had
10:11:20 13 the responsibility of being in charge.
10:11:22 14 Q. And as I said, we'll go
10:11:25 15 through with the Director of Nursing the
10:11:28 16 medication management system, but from your
10:11:31 17 understanding, would that charge nurse also
10:11:34 18 have at the time the access to the medication
10:11:39 19 rooms?
10:11:39 20 A. Yes, she would.
10:11:40 21 Q. And the medication carts?
10:11:42 22 A. Yes.
10:11:42 23 Q. And within the medication
10:11:44 24 rooms, insulin?
10:11:45 25 A. Yes.
10:11:45 26 Q. And within the medication
10:11:47 27 carts, narcotics?
10:11:48 28 A. Yes.
10:11:48 29 Q. And would also have keys to
10:11:52 30 the entire building?
10:11:53 31 A. Yes.
10:11:54 32 Q. Now, your affidavit indicates

10:12:01 that there were a number of issues that arose
10:12:03 during the course of Elizabeth Wettlaufer's
10:12:06 employment; would you agree with that?
10:12:08 A. Yes.
10:12:08 Q. Now, before we get into the
10:12:14 specifics, I just have some general questions
10:12:16 for you. How were human resources issues dealt
10:12:19 with in the home? Was there a human resource
10:12:21 person specifically located in Caressant Care
10:12:26 Nursing Home in Woodstock?
10:12:27 A. Not in my home. At head
10:12:31 office.
10:12:32 Q. And would head office deal
10:12:35 with all issues arising on the performance side
10:12:40 of Elizabeth Wettlaufer or other staff, or
10:12:44 would you deal with some of those issues?
10:12:47 A. I would deal with the issues
10:12:49 up to when we were going to decide to suspend.
10:12:57 If there was any suspensions, we would ask head
10:13:02 office for guidance.
10:13:03 Q. So up to points where you are
10:13:07 going to actually suspend a staff member,
10:13:09 including a Registered Nurse, you would deal
10:13:11 with it within the home itself; is that
10:13:14 correct?
10:13:14 A. For a counselling or a verbal
10:13:18 warning or a written warning, we would deal
10:13:21 with it ourselves.
10:13:22 Q. Did you have any training to
10:13:30 investigate issues that arose? And by
10:13:34 "investigate", Brenda, I mean did you have
10:13:37 training on gathering evidence, taking

10:13:39 1 statements, assessing someone's credibility?
10:13:42 2 Did you have training like that in your
10:13:43 3 position as Administrator?
10:13:45 4 A. No, I didn't. I do believe
10:13:48 5 that we did have -- we had corporate days at
10:13:52 6 head office, and I do believe we had Wanda --
10:14:02 7 and I am going to say Wanda's last name wrong,
10:14:08 8 Sanginesi. I call her Wanda.
10:14:15 9 Q. Wanda will be testifying
10:14:15 10 later as well.
10:14:15 11 A. Okay. I do believe Wanda did
10:14:17 12 give the Administrators an overview at one of
10:14:19 13 our workshops on how to do investigating, and I
10:14:20 14 am not a hundred percent sure on that, but I do
10:14:24 15 think I recall being at a workshop.
10:14:27 16 Q. And do you remember
10:14:28 17 approximately when that would have been?
10:14:29 18 A. I retired in 2016, and Wanda
10:14:41 19 and I didn't work together that long, so I
10:14:44 20 don't know when Wanda started there, but I
10:14:46 21 would think it would have been maybe late 2014
10:14:50 22 or 2015.
10:14:51 23 Q. And from your recollection,
10:14:57 24 that would be -- that would have been the time
10:14:59 25 frame that you would have received some
10:15:02 26 training at least on investigating issues and
10:15:04 27 incidents that arose within --
10:15:05 28 A. Yes, just an overview of, you
10:15:08 29 know, how to conduct an investigation.
10:15:11 30 Q. Now, you indicate within
10:15:16 31 paragraphs 30 to 38 of your affidavit that
10:15:20 32 Caressant Care used progressive discipline, and

10:15:24 perhaps you can just explain to us what you
10:15:27 mean by "progressive discipline"?
10:15:30 A. Progressive discipline is
10:15:35 discipline that is to make the employee aware
10:15:45 that they have done something wrong, and we
10:15:50 start with a counselling. So we identify with
10:15:54 the person that they have, you know, made an
10:15:56 error and discuss it with them and ask for
10:16:00 improvement, hope that they understand.
10:16:04 And then if they repeat that
10:16:06 same type of error, we move that discipline
10:16:11 along. We progress it along to a verbal and
10:16:15 then a written and then suspensions.
10:16:19 And if an employee doesn't
10:16:20 improve, it ends up in termination.
10:16:23 Our discipline program is to
10:16:27 help them and, you know, hope that they see
10:16:31 that they are repeating errors and hope for
10:16:37 improvement.
10:16:37 Q. And you said within your
10:16:43 explanation there that if you saw the same type
10:16:46 of error. Explain to the Commissioner what you
10:16:50 mean by, you know, looking for -- if it is the
10:16:54 same type of error?
10:16:55 A. Well, to use for an example,
10:17:00 if an employee, you know, let's say didn't
10:17:12 toilet a resident, you know, when they were
10:17:15 supposed to, they weren't doing their work as
10:17:18 routine, you know, we would start with our
10:17:24 counselling.
10:17:26 If that same employee didn't
10:17:35 feed right in the dining room, a totally

10:17:40 1 different issue, we would give them a
10:17:42 2 counselling on that.
10:17:44 3 So we would progress then
10:17:49 4 through the incidents as, you know, they were
10:17:54 5 related to -- kind of guide them in the same
10:17:58 6 path. We grouped them in the same path.
10:18:03 7 Absenteeism at one time was
10:18:06 8 disciplined, until we got an Attendance
10:18:11 9 Management Program, but absenteeism was a whole
10:18:14 10 different type of, you know --
10:18:16 11 Q. And just to help, if we can
10:18:18 12 put up your affidavit again, and you did
10:18:21 13 explain it as well in paragraphs 33, 34 and 35
10:18:28 14 of your affidavit.
10:18:31 15 So in 33 you indicate:
10:18:34 16 "In order to explain the
10:18:36 17 discipline process, it is best
10:18:38 18 to use a few examples. Given
10:18:39 19 that a significant amount of
10:18:40 20 medication is handled in
10:18:41 21 long-term care, medication
10:18:42 22 errors would occur. In terms of
10:18:44 23 medication errors, nurses were
10:18:45 24 initially not formally
10:18:47 25 disciplined for making a
10:18:48 26 medication error. Helen
10:18:50 27 Crombez, Caressant Care's
10:18:51 28 Director of Nursing, would meet
10:18:53 29 with the nurse and discuss the
10:18:54 30 error with him or her. The
10:18:56 31 nurse was talked to and
10:18:57 32 counselled. The intention was

10:18:58 to make this nurse a better
10:19:00 nurse and to promote
10:19:01 self-reporting. However, if
10:19:02 some nurses kept making errors,
10:19:05 they were given formal
10:19:06 discipline.
10:19:07 Absenteeism is another issue in
10:19:09 long-term care. Given that
10:19:10 someone may be absent because
10:19:12 they are sick, or injured etc.,
10:19:14 we didn't normally discipline
10:19:16 for absenteeism. We did not
10:19:18 have a formal attendance
10:19:20 management program when I first
10:19:20 started at Caressant Care.
10:19:21 However, we did monitor
10:19:23 absenteeism and did eventually
10:19:25 begin to discipline those
10:19:26 employees whom we felt had too
10:19:28 many sick days. An attendance
10:19:30 management program did come into
10:19:31 effect during my period of time
10:19:35 [...]"
10:19:35 And then finally, 35:
10:19:37 "However, absenteeism is a
10:19:39 different issue than a
10:19:40 medication error. Therefore, if
10:19:42 a Registered Nurse was at the
10:19:44 'written warning' stage for
10:19:46 medication errors, and then
10:19:47 reached the absenteeism
10:19:49 threshold for discipline, we

10:19:50 1 would not put that in the same
10:19:51 2 category as medication errors.
10:19:53 3 In other words, we would not
10:19:55 4 suspend the employee for the
10:19:56 5 absence. We would start him or
10:19:58 6 her at the counselling/education
10:20:00 7 stage for absenteeism."
10:20:02 8 So does that provide another
10:20:07 9 example, Brenda, as to how you would look for
10:20:12 10 similar errors?
10:20:13 11 A. Yes, it does.
10:20:13 12 Q. Now you do indicate at
10:20:29 13 paragraph 38 of your affidavit:
10:20:32 14 "The money for a termination
10:20:33 15 and/or a settlement of a
10:20:35 16 grievance comes from the Nursing
10:20:37 17 and Personal Care budget."
10:20:40 18 Is that the envelope we were
10:20:41 19 talking about earlier?
10:20:42 20 A. Yes, if it was a nurse. Like
10:20:45 21 it wouldn't come from that if it was a
10:20:47 22 housekeeper we were disciplining, but if it was
10:20:49 23 part of the nursing staff, yes, it would.
10:20:51 24 Q. All right, and then you
10:20:53 25 indicate:
10:20:53 26 "Given the financial
10:20:54 27 implication, we would have to
10:20:56 28 notify our Head Office for
10:20:58 29 suspensions and terminations."
10:20:59 30 A. Yes, definitely.
10:21:00 31 Q. Now, you also reference a
10:21:08 32 Collective Agreement. Now, for your registered

10:21:10 staff, the union was the Ontario Nurses
10:21:12 Association; is that correct?
10:21:13 A. Yes.
10:21:13 Q. And in your affidavit at
10:21:16 paragraph 37 you reference a document, and this
10:21:23 is the document I corrected, Commissioner. If
10:21:25 we could just have this document up, 70956. It
10:21:29 is Exhibit "C", Commissioner, to the affidavit
10:21:33 of Ms. Van Quaethem.
10:21:36 And while we are getting that
10:21:48 up, Ms. Van Quaethem, you indicate within your
10:21:51 affidavit that there was -- if there was an
10:21:56 amount of time that had expired between these
10:21:59 errors, if there were no further incidents, the
10:22:02 discipline was taken off the employee's file;
10:22:05 is that your recollection?
10:22:05 A. Yes.
10:22:06 Q. So I just wanted,
10:22:11 Commissioner, to point you to that particular
10:22:16 provision within the Collective Agreement.
10:22:18 And I believe it is page 22,
10:22:26 Amanda?
10:22:31 A. Sorry, page 22 of the
10:22:33 Collective Agreement?
10:22:34 Q. There we go, back, article
10:22:38 10, it's page 21 of the Collective Agreement,
10:22:41 but page 20 -- article 10, go back one. There
10:22:45 we go. Okay, so provision 10.03:
10:22:51 "Letters of discipline shall be
10:22:52 removed from an employee's file
10:22:54 eighteen months following the
10:22:55 receipt of such letters provided

that the employee's disciplinary record has remained discipline free over the eighteen month period. Leaves of absence in excess of thirty continuous calendar days will not count towards the eighteen-month period of time."

Is that what you were referring to, Brenda, in terms of if there was an amount of time without incident, the discipline would go off the file?

A. Yes.

Q. Now, you refer in your affidavit, however, that you generally believed that the time period was a year?

A. Yes, and I did believe that it was a year and that was because of our other Collective Agreement that we used so much more, and that was through CAW and Unifor and their time period was a year, and I just assumed that the ONA agreement was a year as well.

Q. And when you were looking at discipline of registered staff then, would you go back and look at this particular agreement with eighteen months, or were you considering -- you didn't go back and you were considering a year as the time frame?

A. I just thought it was a year and didn't look.

Q. And in terms of that, you have identified that if there was different

10:24:16 1 incidents, you would start the discipline over
10:24:18 2 again at counselling.
10:24:19 3 A. Uhm-hmm.
10:24:20 4 Q. Can you explain, what would
10:24:21 5 happen with this type of provision? Would it
10:24:25 6 have to be -- how did you interpret it? Did
10:24:27 7 you interpret it as a year between incidents or
10:24:33 8 a year between types of incidents?
10:24:34 9 A. A year between types of
10:24:36 10 incidents. So if we had disciplined someone
10:24:41 11 for absenteeism and then they were fine for a
10:24:44 12 year, we would start over again.
10:24:46 13 Q. Now, you have had an
10:24:55 14 opportunity within the course of the Inquiry,
10:24:59 15 even though you have left Caressant Care, to
10:25:01 16 review Elizabeth Wettlaufer's employment file;
10:25:05 17 is that correct?
10:25:07 18 A. Yes.
10:25:07 19 Q. The documents that were
10:25:08 20 contained in it?
10:25:10 21 A. The documents that are
10:25:11 22 contained in here, yes.
10:25:12 23 Q. And do you have an
10:25:14 24 independent full recollection of all of the
10:25:17 25 incidents that are referred to in the documents
10:25:20 26 in your affidavit?
10:25:20 27 A. No, I do not.
10:25:22 28 Q. So let's talk in generalities
10:25:26 29 before then we get into Ms. Wettlaufer.
10:25:30 30 In general, if you received a
10:25:34 31 complaint from a staff member about another
10:25:35 32 staff member, what would your process be? How

10:25:37 would you handle that type of a situation?
10:25:39 A. The first thing I would do is
10:25:45 I would look at the document and see first if
10:25:49 the timelines are relevant. And by that I mean
10:25:54 at times employees report something to you that
10:25:58 happened a couple of months ago, a month ago.
10:26:05 So I look at the relevance of that document.
10:26:12 I investigate then with the
10:26:15 person who normally would write the complaint,
10:26:23 and then if there was anyone else involved, we
10:26:25 would investigate with them as well.
10:26:27 Q. When you say "investigate
10:26:29 with them", do you mean do you speak to them?
10:26:31 A. Yeah, just speak to them,
10:26:32 yes.
10:26:32 Q. And would it be you doing --
10:26:35 for registered staff, would it only be you
10:26:38 doing those types of investigations?
10:26:39 A. No, normally it would be
10:26:40 Helen or Helen and I together, or it could be
10:26:45 me alone as well, but normally we do things
10:26:48 together and knew what each other were doing.
10:26:52 Q. Now, was there a separate
10:26:54 process if you received a complaint from a
10:26:56 resident or a family member about a staff
10:26:59 person, a registered staff person?
10:27:02 A. Yes, we would deal with it
10:27:04 immediately.
10:27:04 Q. And in those circumstances,
10:27:08 how would you deal with that type of a
10:27:10 complaint?
10:27:10 A. Well, we like to resolve the

10:27:13 1 complaint immediately, so we would investigate.
10:27:22 2 Q. Would you speak to the family
10:27:24 3 member or the resident that was complaining?
10:27:26 4 A. Oh, yes.
10:27:27 5 Q. Now, did you document those
10:27:29 6 types of investigations as well?
10:27:32 7 A. Document? Well, it depends
10:27:38 8 on the type of the complaint. Like if a family
10:27:42 9 member would come and say that, you know, we
10:27:46 10 lost clothing or, you know, yeah, no, we would
10:27:50 11 just look for the clothing, find it, or if we
10:27:54 12 couldn't find it, phone them and say, you know,
10:27:56 13 we haven't found it but we'll keep on looking.
10:28:00 14 It would depend on the type of complaint.
10:28:01 15 Q. And would there be any
10:28:04 16 responsibility set upon you to alert the
10:28:07 17 Ministry if there were complaints from family
10:28:09 18 members or residents?
10:28:10 19 A. Yes, if it was abuse,
10:28:21 20 immediate reporting.
10:28:21 21 Q. And I think you have
10:28:24 22 identified in paragraph -- sorry, Commissioner,
10:28:32 23 just give me a moment -- in paragraph 16 of
10:28:34 24 your affidavit, in terms of your reporting
10:28:38 25 obligations there were certain things that you
10:28:42 26 were required to immediately report to the
10:28:44 27 Ministry; is that correct?
10:28:45 28 A. Yes.
10:28:45 29 Q. And so you have summarized
10:28:47 30 some of those things in paragraph 16 of your
10:28:50 31 affidavit --
10:28:51 32 A. Yes.

10:28:51 Q. -- as improper or incompetent
10:28:59 treatment of a resident -- actually, if we can
10:29:01 get that up, Amanda.
10:29:11 Your understanding of those
10:29:20 reporting obligations, immediate reporting
10:29:23 obligations were in respect of:
10:29:25 "Improper or incompetent
10:29:27 treatment of a resident by a
10:29:28 staff member that resulted in
10:29:29 harm or the risk of harm to a
10:29:31 resident;
10:29:32 Abuse of a resident or neglect
10:29:34 of a resident by anyone that
10:29:36 resulted in harm or the risk of
10:29:37 harm to the resident;
10:29:38 Unlawful conduct that resulted
10:29:40 in harm or a risk of harm to a
10:29:42 resident;
10:29:43 A missing or unaccounted for
10:29:45 controlled substance; and
10:29:48 An accident that causes an
10:29:49 injury for which a resident is
10:29:50 taken to hospital and that
10:29:52 results in a significant change
10:29:53 in the resident's health."
10:29:56 Were those items that you would
10:29:58 have to specifically immediately report to the
10:30:06 Ministry?
10:30:07 A. Yes.
10:30:07 Q. And what was your
10:30:08 understanding in terms of these reporting
10:30:12 obligations of the types of abuse or the

10:30:19 1 definition of "abuse" contained within the
10:30:21 2 regulations? Sorry, the word "abuse" is in the
10:30:24 3 regulations, I should clarify that, but what
10:30:27 4 was your understanding of the types of
10:30:28 5 behaviour that would constitute abuse?
10:30:34 6 A. There was different types,
10:30:35 7 you know, verbal, physical, psychological.
10:30:41 8 There was a lot of different types of abuse.
10:30:45 9 Q. But there was at minimum
10:30:48 10 verbal, physical, psychological and neglect, as
10:30:52 11 I understand it --
10:30:53 12 A. And neglect.
10:30:54 13 Q. -- within this, your
10:31:03 14 affidavit here.
10:31:05 15 Now, with respect to Elizabeth
10:31:09 16 Wettlaufer, before we get into her discipline,
10:31:12 17 can you tell me, apart from dealing with her in
10:31:13 18 discipline settings, what type of interactions
10:31:16 19 would you have had with her over the years?
10:31:19 20 A. I would see her -- my office
10:31:20 21 was on the lower level where the employees came
10:31:23 22 in to work. I would see her coming in, if she
10:31:25 23 came in that entrance where my office was. She
10:31:33 24 would have a smile on her face. She would be
10:31:37 25 friendly. She was respectful. I saw her come
10:31:44 26 in off shift. I would see her bringing pie or
10:31:47 27 something in, goodies for the staff or for
10:31:56 28 residents. If I was on the floor and she was
10:31:59 29 working, she would be respectful. I saw her
10:32:03 30 happy. Yeah, she -- nothing stood out to me
10:32:07 31 different than any other employee.
10:32:10 32 Q. Did you see or happen to see

10:32:16 1 when you were on the floor how she was with
10:32:17 2 residents?
10:32:18 3 A. Yes, she was very caring.
10:32:21 4 She interacted well with residents. She liked
10:32:24 5 to laugh. She liked to joke. She would
10:32:28 6 interact with them.
10:32:29 7 Q. Is it safe to say, however,
10:32:39 8 that the majority of your interactions with
10:32:44 9 Elizabeth Wettlaufer would actually be related
10:32:46 10 to issues that arose involving her?
10:32:49 11 A. I don't know if most of my
10:32:54 12 interactions were that way. The most in-depth
10:33:01 13 conversations were there. But no, I would, you
10:33:07 14 know, see her more often I think on the floor
10:33:09 15 or attending functions. We would give our
10:33:17 16 residents a Christmas party every year, and we
10:33:20 17 divided the home up into different areas,
10:33:23 18 because it was so large and we didn't have a
10:33:25 19 large enough auditorium for our Christmas
10:33:28 20 parties. Beth would come down and interact
10:33:33 21 with them at the Christmas parties.
10:33:38 22 You know, we -- the management
10:33:41 23 team would make special food for the residents
10:33:43 24 for that evening, because we wanted them to
10:33:45 25 experience Christmas like we experience with
10:33:49 26 our families, and she would participate and we
10:33:56 27 would have music and be dancing and she would
10:33:59 28 be laughing.
10:34:01 29 And you know, I saw her at a lot
10:34:03 30 of different times, and I can't remember a time
10:34:09 31 that I ever thought, oh, Bethe, you are not
10:34:13 32 being respectful or, you know -- but yes, I did

10:34:18 discipline her many, many, many times, and even
10:34:23 in those disciplines, she was respectful.
10:34:25 Q. Would she accept
10:34:32 responsibility when you were disciplining her?
10:34:34 A. Yes, she would. She would
10:34:35 say, I didn't do that right; I will try; I will
10:34:41 do better.
10:34:41 Q. So if an incident arose with
10:34:50 Elizabeth Wettlaufer and you were going to meet
10:34:53 with her, number one, would she have a union
10:34:56 representative with her?
10:34:57 A. If we were going to meet with
10:35:00 her, yes, she would have another member of the
10:35:03 nursing team. We did not have an ONA rep in
10:35:06 the home, and the ONA rep - and by an "ONA"
10:35:14 rep, I'm meaning a nurse employed by us - would
10:35:17 take the responsibility of being the
10:35:18 representation between us and ONA.
10:35:21 No one wanted to take that
10:35:23 responsibility for a lot of years, so a
10:35:26 different member of the registered staff team
10:35:29 would attend those meetings with her.
10:35:31 Q. We have seen or we will see
10:35:34 there were a number of meetings where Karen
10:35:38 Routledge, who I understand is a Registered
10:35:40 Nurse, attended. Was she a representative or
10:35:42 one of the --
10:35:43 A. Karen at one time was the ONA
10:35:45 rep in the home, and then she no longer wanted
10:35:48 to do that responsibility. But she would still
10:35:53 attend as a representative with any nurse that
10:35:58 we were talking to or we would have just

10:36:01 1 another member of the nursing staff.
10:36:05 2 And I can't say to when Karen
10:36:09 3 stepped down from that duty as ONA rep. I
10:36:13 4 don't know what year.
10:36:13 5 Q. Was Karen also a Registered
10:36:19 6 Nurse on the floor?
10:36:20 7 A. Yes, she was.
10:36:21 8 Q. When she would attend these
10:36:23 9 particular meetings, would her -- would
10:36:27 10 somebody replace her on the floor or would
10:36:29 11 people just simply continue on with their work?
10:36:33 12 A. Yes.
10:36:34 13 Q. So if I can just interrupt
10:36:35 14 you for a second before the transcript people
10:36:39 15 become very displeased with me, if you can wait
10:36:42 16 until I -- I know you are probably anticipating
10:36:45 17 the type of question that I am asking you
10:36:47 18 because you have done an affidavit, but if you
10:36:49 19 can just wait until I complete the full
10:36:51 20 question, because it is being transcribed, and
10:36:56 21 if we don't do that, they have to tonight keep
10:36:58 22 saying Brenda said two words, Elizabeth said
10:37:03 23 one word --
10:37:04 24 A. Yes.
10:37:04 25 Q. And all witnesses do that, it
10:37:07 26 is not usual. Counsel interrupt each other all
10:37:10 27 the time as well, except not as nicely.
10:37:12 28 THE COMMISSIONER: Really?
10:37:15 29 BY MS. HEWITT:
10:37:15 30 Q. Once in awhile we let the
10:37:17 31 judges get involved as well.
10:37:19 32 All right, so Karen Routledge

would be -- would she come in off shift or would you have to have these meetings when she was the ONA rep while she was on shift, or was it a combination?

A. I believe that it would be when she is on shift.

Q. So you are having a meeting with Elizabeth Wettlaufer or any other registered staff member that is represented by ONA, and simply that person would come in, but no one would replace that person in providing care for the residents during that period of time?

A. No.

Q. When an issue arose and you were going to meet with Elizabeth Wettlaufer, what process would you do to determine where she was, if at all, along your stream of previous disciplines? Did you have a spreadsheet? Did you have a list?

A. No, we didn't have a spreadsheet. Normally, we didn't have time to review the file, but on my computer, as I did most of the tracking of the disciplines or typing up of the disciplines, you know, when I clicked on "Union", my file was called "Union", and then, you know, the name Wettlaufer would come up and the date of the last discipline would be there. We just kind of think, oh, yeah, it has been this long since we have -- you know, we wouldn't really go to that discipline and read a previous one. We just

kind of looked at the tracking of it on the computer.

Q. Now, if I can take you briefly to paragraph number 49, I believe it is, of your affidavit, your affidavit sets out various categories of these types of incidents, and the first one relates to absenteeism. And my understanding from paragraph 49 is that as much as possible there was an attempt to pull out, from all of the disciplines, what related to absenteeism; is that correct?

A. Yes.

Q. Sorry, did you --

A. Yes, we would try to look at them and progress within the type of discipline.

Q. But this, as I understand from you, you didn't keep this type of a list?

A. No.

Q. But pulling out the different absenteeism discipline, you were able to create this list?

A. Yes.

Q. And so that indicates that you progressed from counselling in 2009 to a verbal warning for absenteeism in 2010, two written warnings in 2011, and a one-day suspension in 2011, and then counselling again in 2013; is that your recollection, having reviewed the various counselling documents?

A. Yes.

Q. Counselling and discipline

10:40:45 documents?
10:40:45 A. Yes.
10:40:46 Q. Now, in respect of Elizabeth
10:40:55 Wettlaufer, were there -- before we get into
10:40:57 details, were there issues about her conduct in
10:41:00 terms of any complaints about inappropriate
10:41:04 comments or conduct?
10:41:05 A. Yes.
10:41:06 Q. Now, were those a separate
10:41:10 category, from your perspective?
10:41:12 A. Yes.
10:41:12 Q. So if we can go then to
10:41:16 paragraph 52 of the affidavit, and we are going
10:41:30 to get into these, but just for the benefit of
10:41:34 the Commissioner and the public, they are
10:41:35 listed there.
10:41:37 So you have identified a
10:41:40 counselling with Elizabeth Wettlaufer in
10:41:42 September 2009; a verbal warning in 2009, a few
10:41:48 months later; 2010, a counselling; and 2011, a
10:41:54 counselling.
10:41:54 A. Yes.
10:41:55 Q. So I want to take you through
10:41:57 some of these so we can understand the
10:41:59 processes that you undertook and also
10:42:02 understand the types of incidents that you were
10:42:04 dealing with at this point in time.
10:42:05 And at Exhibit Number E to your
10:42:13 affidavit is document number 16898, if we can
10:42:24 have that up, please.
10:42:48 And this document purports to be
10:42:59 a letter from Libby Gunter. Was she a staff

10:43:05 1 member?
10:43:05 2 A. She was a Registered Nurse.
10:43:06 3 Q. And it is addressed to you?
10:43:08 4 A. Yes, it is.
10:43:08 5 Q. And Ms. Gunter identifies in
10:43:13 6 her letter:
10:43:15 7 "It has been stated to myself by
10:43:16 8 another Registered Staff (Beth
10:43:19 9 W.) [...]"
10:43:21 10 And do you understand that to be
10:43:22 11 Elizabeth Wettlaufer?
10:43:23 12 A. Yes.
10:43:23 13 Q. "[...] that I should watch my
10:43:26 14 back as another staff member
10:43:28 15 (Jill Fletcher) was making
10:43:30 16 statements about me behind my
10:43:32 17 back."
10:43:33 18 And she identifies a number of
10:43:34 19 statements.
10:43:35 20 So from your perspective, what
10:43:37 21 was going on in this particular situation?
10:43:44 22 A. I believe that Bethe was
10:43:45 23 telling Libby that, you know, this other nurse
10:43:48 24 was talking to her behind her -- or talking
10:43:52 25 about her behind her back, so she was informing
10:43:54 26 Libby of what the other nurse was saying.
10:44:02 27 Q. But that came to you in the
10:44:03 28 form of a complaint. Was that a complaint
10:44:05 29 about Elizabeth Wettlaufer or was --
10:44:05 30 A. No.
10:44:08 31 Q. -- that a complaint about the
10:44:09 32 other nurse?

10:44:09 A. I believe it was just
10:44:17 informing me of what was being said, and then,
10:44:22 you know, for me to be aware and to
10:44:26 investigate.
10:44:27 Q. Now, if I can -- my
10:44:30 understanding is that you did meet with
10:44:33 Elizabeth Wettlaufer with a union
10:44:34 representative. If I can turn you,
10:44:38 Commissioner -- for your purposes,
10:44:42 Commissioner, there is separating blue tabs
10:44:47 within that same exhibit, so the next document,
10:44:51 sorry, the third document in would be document
10:44:54 16899, which would be handwritten notes.
10:44:57 And I am taking you through this
10:45:24 partly, Commissioner, and Brenda, to establish
10:45:27 the process that would be undertaken in terms
10:45:29 of these issues. They are referred to in the
10:45:31 affidavit.
10:45:31 But they are handwritten notes,
10:45:36 Brenda, and in terms of this, can you tell me
10:45:39 whose handwriting would appear on this
10:45:41 particular document?
10:45:41 A. That is my handwriting.
10:45:43 Q. So what would be the process?
10:45:46 You indicate that -- or sorry, the document
10:45:49 indicates that Ms. Wettlaufer is here. Marie,
10:45:54 who would Marie be?
10:45:55 A. Marie Buckrell was the
10:46:00 Director of Nursing at one time, along with
10:46:02 Helen Crombez, and then she was the Assistant
10:46:08 Director of Nursing after a period of time, and
10:46:10 I don't know what -- when that role changed.

10:46:13 So she was either the Director
10:46:15 of Nursing or Assistant Director of Nursing.
10:46:18 Q. So do I understand your
10:46:19 evidence to be then that at one time Caressant
10:46:22 Care had two Directors of Nursing?
10:46:24 A. At one time, yes.
10:46:25 Q. And then that was changed to
10:46:26 a Director of Nursing and an Assistant Director
10:46:30 of Nursing? Why that change?
10:46:32 A. Caressant Care had bought the
10:46:37 nursing home in Norwich and moved the residents
10:46:41 from Norwich when we built the new section, and
10:46:46 this is prior to me starting there. And Marie
10:46:49 Buckrell was a Director of Nursing at the
10:46:54 Norwich home, and so they brought her over as
10:46:57 Director of Nursing, you know, and had two
10:47:06 Directors of Nursing.
10:47:07 But then Mr. Lavelle had called
10:47:12 me to head office at one time and said, you
10:47:14 know, he thought we should do the same kind
10:47:20 of -- I can't think of the word for it, but to
10:47:25 have the same stature in each of the homes with
10:47:28 a Director of Nursing and either Assistant
10:47:30 Director of Nursing. And he asked me who --
10:47:35 what he should do, and so I had said that I
10:47:39 thought that, you know, Helen had been the
10:47:41 Director of Nursing there for almost 30 years
10:47:47 and that Marie should be made the Assistant
10:47:51 Director of Nursing, and that came about at
10:47:53 that time.
10:47:53 Q. All right, and so Helen
10:47:55 Crombez remained in that position and Marie

10:47:59 Buckrell took on the Assistant?
10:48:02 A. And I think we called her an
10:48:04 Associate Director of Nursing, not an
10:48:07 Assistant.
10:48:07 Q. All right, and Karen R.,
10:48:10 that would be Karen Routledge?
10:48:11 A. Yes.
10:48:11 Q. So in these meetings, who
10:48:15 would be responsible for asking questions? Who
10:48:17 would be responsible, if anyone, for making
10:48:20 sure notes were taken, if at all?
10:48:22 A. Normally, two managers were
10:48:25 present at every interview, and in this case I
10:48:33 wrote the notes, so that meant that Marie
10:48:37 Buckrell did the talking. Normally, in the
10:48:39 cases of something to do with registered staff,
10:48:43 the nurse, you know, the Director of Nursing or
10:48:46 the Associate Director of Nursing would do the
10:48:49 talking and I would be the notetaker. Not
10:48:56 always that way, but a lot of times that way.
10:48:58 Q. All right, and two thirds of
10:49:00 the way down that page, if we could just scroll
10:49:02 down a bit, Amanda, there is a line that says:
10:49:08 "What did you wish to accomplish
10:49:09 by passing on this information."
10:49:11 That is your handwriting?
10:49:13 A. That is my handwriting, so
10:49:15 Marie was doing the talking, and Beth's
10:49:20 response was:
10:49:23 "I just felt Libby should
10:49:26 confront Jill."
10:49:27 Q. And can you just read the

10:49:28 next paragraph for us?
10:49:29 A. "Do you know the proper
10:49:33 reporting procedures of the
10:49:34 home."
10:49:35 So Marie Buckrell would have
10:49:37 said that, and I believe -- I don't know if the
10:49:42 next one would be Marie still talking or Beth,
10:49:47 but:
10:49:48 "We need to work as a team, you
10:49:50 are a professional and we expect
10:49:52 a professional manner at all
10:49:54 times."
10:49:55 So that was Marie Buckrell
10:49:58 talking to Beth.
10:49:59 Q. All right, thank you. And I
10:50:00 won't take you to the document. I will note,
10:50:07 Commissioner, further on in that same exhibit
10:50:09 at 16901 are typewritten notes of that
10:50:12 particular meeting with a more fulsome account.
10:50:17 And then at the end it says:
10:50:19 "Bethe apologised at the end of
10:50:20 the meeting for handling this
10:50:22 poorly."
10:50:23 So I believe you classified this
10:50:24 as a counselling situation?
10:50:25 A. Yes, we classified this as a
10:50:28 counselling.
10:50:29 Q. Did you -- and we don't have
10:50:30 it in the record here, but did you speak to the
10:50:36 other nurse about whom Ms. Wettlaufer was
10:50:38 saying was making these comments?
10:50:39 A. I can't recall that.

10:50:40 1 Q. Now, the next incident that
10:50:49 2 you refer to in your affidavit at Exhibit F,
10:50:56 3 Commissioner, of -- which reminds me,
10:51:00 4 Commissioner, did we make this an exhibit
10:51:02 5 number?
10:51:03 6 Okay, could we make this
10:51:05 7 affidavit the next exhibit number at the
10:51:08 8 Inquiry, please?
10:51:09 9 THE COMMISSIONER: Yes, so
10:51:11 10 according to my notes, but Madam
10:51:14 11 Clerk, you can correct me if I'm
10:51:15 12 wrong, I show it as Exhibit 9.
10:51:21 13 THE COURT CLERK: Exhibit 10, I
10:51:22 14 believe, Commissioner.
10:51:23 15 THE COMMISSIONER: So what was
10:51:23 16 9?
10:51:25 17 THE COURT CLERK: 9 was the
10:51:25 18 Overview Report of the Ministry
10:51:29 19 of Health and Long-Term Care.
10:51:29 20 MS. HEWITT: The first four
10:51:29 21 should be the foundational, the
10:51:31 22 transcript, and then the four
10:51:32 23 overview.
10:51:33 24 THE COMMISSIONER: Yes, thank
10:51:33 25 you. So Exhibit 10 then, the
10:51:35 26 affidavit of Brenda Van
10:51:37 27 Quaethem.
10:51:37 28 EXHIBIT NO. 10: Affidavit of
10:51:35 29 Brenda Van Quaethem.
10:51:39 30 MS. HEWITT: And I apologize,
10:51:40 31 Commissioner, for not having
10:51:41 32 done that at the very beginning.

10:51:42 THE COMMISSIONER: We would have
10:51:43 picked that up.
10:51:44 BY MS. HEWITT:
10:51:46 Q. And it gets difficult, so
10:51:48 explain it. So Exhibit No. F of Exhibit No. 10
10:51:52 is a letter dated December 3, 2009, and Amanda,
10:51:58 that would be doc ID 16895.
10:52:23 That is a letter dated December
10:52:25 3rd, 2009, and it identifies I believe your
10:52:31 signature at the end, Brenda?
10:52:34 A. Yes, it is.
10:52:35 Q. And that letter states:
10:52:38 "As discussed in our
10:52:39 investigative meeting you are
10:52:40 receiving a verbal warning
10:52:42 regarding discrimination and
10:52:42 harassment of a co-worker.
10:52:44 Caressant Care has a policy on
10:52:46 harassment that you have
10:52:47 violated.
10:52:47 Your comments were taken by
10:52:49 another worker as rude,
10:52:50 degrading and offensive because
10:52:52 of a remark regarding the
10:52:54 English language. This is not
10:52:55 acceptable and will not be
10:52:56 tolerated."
10:52:57 Now, we did note from our review
10:53:01 of the material that Caressant Care provided in
10:53:05 response to our summons that there was no notes
10:53:07 related to this particular situation. Do you
10:53:10 have any independent recollection of what the

10:53:13 matter was about?
10:53:16 A. No, I don't. Only, and I am
10:53:19 surmising from this letter, that she must have
10:53:22 made an inappropriate remark to someone who did
10:53:29 not speak English well.
10:53:31 Q. Who was responsible for
10:53:34 keeping these types of letters of discipline
10:53:37 and any notes from meetings, et cetera,
10:53:39 together?
10:53:47 A. They were filed in my office,
10:53:48 so I would say me. But normally if we took
10:53:56 notes, we would attach them like right behind
10:53:58 the discipline. In this case, I don't know if
10:54:05 it was someone verbally told us that she, you
10:54:08 know -- I'm only guessing.
10:54:09 Q. I don't want you to guess.
10:54:10 A. So you don't want me to
10:54:12 guess, but if there was no written paperwork,
10:54:14 I'm thinking it was just stated.
10:54:18 Q. All right, so that is the
10:54:19 extent that we know. The date was that as of
10:54:23 December 3rd, 2009, Elizabeth Wettlaufer had
10:54:27 received a written warning in respect of -- or
10:54:32 sorry, a verbal warning in respect of her
10:54:35 behaviour, and it appears about a comment about
10:54:38 another person and the English language; is
10:54:41 that correct?
10:54:41 A. Yes.
10:54:41 Q. Now, in this realm of
10:54:48 misconduct or work performance issues, the next
10:54:53 incident appears to be shortly thereafter in
10:54:55 January of 2010, and this incident is referred

10:55:02 to in paragraphs 58 to 60 of your affidavit.
10:55:07 And it appears -- and this is
10:55:14 at, Commissioner, Exhibit "G" of the affidavit,
10:55:28 if we can just go to the document number 16888.
10:55:49 While we are turning there,
10:55:51 Commissioner, I do note that we have redacted
10:55:57 the documents that we received to remove the
10:56:00 entire name of residents that would have been
10:56:02 contained in the document, unless they were
10:56:05 victims, and we have only identified residents
10:56:07 by initials for the purposes of privacy.
10:56:12 So this document will look a
10:56:14 little bit strange to you because there are
10:56:18 parts of it that are blocked out and you'll
10:56:21 just see lettering.
10:56:22 And I am just going to read from
10:56:28 this letter and then ask you some questions,
10:56:32 Brenda. It states "Dear Brenda", so I'm
10:56:36 assuming this was delivered directly to you?
10:56:38 A. Yes, I would say that it was.
10:56:41 Q. And it says:
10:56:42 "I would like to inform you of
10:56:43 some recent happenings.
10:56:45 On Sunday January 10th, I spoke
10:56:47 to Helen Crombez regarding Beth
10:56:49 W. constantly arriving late for
10:56:50 work. Beth worked after me on
10:56:54 the Monday myself 3-11, Beth
10:56:56 nights 11-7. Again she walked
10:56:59 in late. Jeanette and myself
10:57:02 were waiting for her to arrive.
10:57:04 Beth stood behind me that night

10:57:06 1 when I was about to start
10:57:07 2 report. I started with [TH]",
10:57:11 3 the name of a resident, "I was
10:57:13 4 about to tell her he was sick
10:57:14 5 and then focus on the daily
10:57:16 6 calendar and then give report
10:57:17 7 from the work sheet in order.
10:57:19 8 She leaned over my shoulder,
10:57:21 9 pointed to room number [...]",
10:57:23 10 and we have again, Commissioner,
10:57:25 11 taken out room numbers, "[...]
10:57:28 12 on the work sheet and then
10:57:29 13 stated 'do it in order.'
10:57:32 14 I followed the report sheet;
10:57:34 15 when reading off medications I
10:57:35 16 said '[N] Tylenol' and when
10:57:40 17 given, [K] Tylenol given and
10:57:42 18 why."
10:57:42 19 Now, I do note what the actual
10:57:45 20 document says here, Commissioner, is the last
10:57:49 21 names of residents, so "N" and "K" are simply
10:57:52 22 the last names. So the document indicates that
10:57:55 23 this particular nurse was going through the
10:57:58 24 report and simply referring to the residents by
10:58:00 25 their last name, Smith Tylenol, Johnson, et
10:58:06 26 cetera.
10:58:06 27 It then refers back to Beth
10:58:09 28 Wettlaufer:
10:58:09 29 "She started talking '[AA]'
10:58:13 30 '[BB]' followed by, 'you are so
10:58:14 31 cold', 'you are so insensitive',
10:58:18 32 'how would you like it Fletcher

Fletcher'."
So that this is the nurse that is complaining, Jill Fletcher.
"'How would you like it Fletcher Fletcher'. I told her it did not bother me and just ignored her after that.
Last nite I worked 3-11, Beth worked 11-7. She had expressed to me after report she had a boil. When I was walking away from the desk she said don't you want to see this thing. Before I could respond she pulled down the right side of her uniform bottoms so she could show it to me. I am sure she is not aware that she was exposing part of her groin. I told her to put some Bactroban" - I'm not quite sure what that is - "on it and dressing. I then left. I spoke with Karen R. about the things that continue with Beth, and she agreed I should bring it to your attention."
So what was your recollection having received this particular letter as to what you then did and what the outcome was?
A. It is hard to recollect what I thought at the time. I would think, when I read it, that why is Jill giving me -- if this

10:59:53 1 was so bad on Sunday, January the 10th, why was
10:59:58 2 it reported on January 19th?
11:00:01 3 I thought, well, Beth didn't
11:00:06 4 like the residents being called by their last
11:00:09 5 name. We were a home and we called people, you
11:00:12 6 know, by their first names. We asked residents
11:00:17 7 how they liked to be referred to, and most of
11:00:19 8 them, I would say, I think a hundred percent of
11:00:23 9 them liked to be called by their first name.
11:00:25 10 So I would just think probably
11:00:36 11 that Beth and Jill didn't get along that well.
11:00:41 12 Q. All right. And the evidence
11:00:44 13 indicates that there was a meeting with
11:00:47 14 Elizabeth Wettlaufer to have her explain some
11:00:49 15 of these issues, and that, if I can turn you,
11:00:52 16 Commissioner, to doc ID 16890. It is at
11:01:01 17 Exhibit G and it should be your second document
11:01:03 18 in, handwritten notes. And again, it appears
11:01:19 19 that at this meeting is Elizabeth Wettlaufer,
11:01:23 20 Karen Routledge, yourself and Helen Crombez.
11:01:27 21 And again, whose handwriting is this?
11:01:28 22 A. This is Helen's.
11:01:30 23 Q. All right.
11:01:30 24 A. So I did the talking.
11:01:31 25 Q. And it goes down to:
11:01:42 26 "Spoke to Jill about something
11:01:43 27 that bothered me immensely,
11:01:46 28 rhyming off people's names -
11:01:48 29 last name only, sounds very
11:01:50 30 impersonal."
11:01:51 31 Do you know who is speaking
11:01:52 32 there?

11:02:07 A. Where are you?
11:02:08 Q. Sorry, let me start off.
11:02:11 That might help you a bit. At the very
11:02:13 beginning it says:
11:02:14 "Do you have any problems with
11:02:15 any other registered staff".
11:02:16 Who would be speaking with that?
11:02:18 A. I would say me.
11:02:20 Q. All right.
11:02:20 "Differences with Libby and
11:02:23 Jill".
11:02:23 A. That would be Beth.
11:02:24 Q. And then it says:
11:02:25 "Spoke to Jill about something
11:02:26 that bothered me immensely,
11:02:28 rhyming off people's names -
11:02:30 last name only, sounds very
11:02:32 impersonal."
11:02:38 A. I would say that is Beth.
11:02:39 Q. Okay. And then it continues:
11:02:44 "Rhyming off people's names -
11:02:46 last name only" -- sorry, I did
11:02:48 that.
11:02:49 "What's wrong with using last
11:02:51 names. You don't know the
11:02:51 resident's first name" -- sorry,
11:02:53 "What's wrong with using last
11:02:55 names. You don't know the
11:02:56 resident's first name, use
11:03:00 Mrs. or Mr. The resident sounds
11:03:03 impersonal, sounds like an army
11:03:05 camp. It is one of my strengths

11:03:06 1 my compassion for the
11:03:12 2 residents."
11:03:13 3 A. I would believe that is Beth.
11:03:15 4 Q. All right. And it does
11:03:23 5 identify, if we go down the page, it does
11:03:29 6 identify:
11:03:31 7 "Make sure you have permission
11:03:35 8 [...]"
11:03:35 9 MS. STRATTON: Would you like me
11:03:35 10 to highlight it?
11:03:35 11 BY MS. HEWITT:
11:03:41 12 Q. Sure, it is just a little
11:03:42 13 difficult to read that paragraph:
11:03:44 14 "Make sure you have permission
11:03:45 15 to before you show or say where
11:03:46 16 it is" - and this is talking
11:03:48 17 about the boil - "before you
11:03:50 18 show or say where it is before
11:03:51 19 you show. You made a staff
11:03:53 20 member [being]" --
11:03:54 21 Sorry, we might need a break
11:03:56 22 soon or my voice might need a break soon,
11:03:59 23 Commissioner.
11:04:01 24 "You made a staff member very
11:04:03 25 uncomfortable."
11:04:04 26 So who would be speaking then?
11:04:06 27 A. I think I would be.
11:04:10 28 Q. All right, and in respect of
11:04:11 29 this particular situation, your affidavit
11:04:17 30 indicates that you gave Ms. Wettlaufer
11:04:25 31 counselling on this particular occasion. So
11:04:29 32 you had a counselling in September. You went

11:04:32 1 up to a verbal warning in December. This is a
11:04:35 2 month and a half later, and in this particular
11:04:38 3 situation you provide her with a counselling.
11:04:40 4 So can you identify why that
11:04:44 5 particular step would have been taken?
11:04:45 6 A. We didn't progress because --
11:04:50 7 I believe we didn't progress because I think we
11:04:52 8 would have felt at that time that Beth was
11:04:55 9 trying to show compassion for the residents and
11:05:01 10 that she wasn't -- she didn't say something
11:05:03 11 just, you know, to cause grief to Jill, but she
11:05:11 12 was trying to make report be more personable
11:05:14 13 and be more respectful to our residents.
11:05:17 14 So yes, it did warrant to talk
11:05:19 15 to her, but didn't warrant to move up in
11:05:21 16 discipline.
11:05:22 17 Q. So within your progressive
11:05:26 18 discipline, you could go down, you felt that
11:05:29 19 you were able to go down a step as well?
11:05:30 20 A. Yes.
11:05:31 21 Q. And the next document, the
11:05:37 22 next incident occurs in June 2011, and we are
11:05:42 23 now then some 16 months past this incident with
11:05:50 24 Jill Fletcher and report, and if I can just
11:05:54 25 turn you to that particular situation. And I
11:06:09 26 am going to ask that we pull up a document that
11:06:16 27 is not contained within the affidavit,
11:06:19 28 Commissioner, but it is contained within the
11:06:23 29 evidence, Exhibit 6, which is the Facilities
11:06:27 30 Overview Report.
11:06:29 31 If we can pull up document
11:06:37 32 16861, you refer to this document in your

11:06:39 affidavit. It is an email to Cheryl MacDonald.
11:06:42 It is just not attached. Who is Cheryl
11:06:48 MacDonald?
11:06:48 A. Cheryl MacDonald worked at
11:06:50 head office in human resources. I don't know
11:06:53 her official title, but she was in human
11:06:56 resources.
11:06:57 Q. And under what type of
11:07:01 circumstances would you reach out to Ms.
11:07:03 MacDonald?
11:07:03 A. When giving disciplines.
11:07:08 Prior to Wanda starting with the company, we
11:07:13 had -- Wanda took over from Wayne Hume when he
11:07:20 retired. And then Wayne Hume and Cheryl
11:07:24 MacDonald were both in human resources and
11:07:27 Cheryl would attend like grievance meetings
11:07:33 with me. Wayne Hume would too on occasion.
11:07:36 But Cheryl was my contact person in head office
11:07:40 for when I was disciplining.
11:07:44 She was also the WSIB contact
11:07:49 from head office as well.
11:08:00 Q. Thank you. Now I'll just
11:08:00 give a bit of background. Contained in your
11:08:00 affidavit is a document 16866. I don't want
11:08:03 you to go there at this point, Amanda, but it
11:08:05 identifies handwritten notes that an employee
11:08:07 had concerns that a comment was made about how
11:08:10 a staff member looked. And my understanding is
11:08:14 that after the meeting with Ms. Wettlaufer, you
11:08:17 reached out to Cheryl MacDonald; is that
11:08:20 correct?
11:08:20 A. Yes.

Q. And in that email, you indicate:

"In follow-up to the complaint from Lauren Hall regarding inappropriate comments by Beth Wettlaufer R.N., Helen and I spoke with Bethe with Karen Routledge, Union Rep. present. Bethe said she did not think her comments were inappropriate and she felt because she is gay that Lauren is saying anything. I told her I didn't know if it had to do with her being gay. I told her I deal with complaints that come to me when they occurred in the workplace. I said she has to stop and Bethe said she would. We also discussed that she is talking outside the workplace with a common friend her and Lauren. She said she did not talk out of place[,] the friend said she knew the information from Lauren on Lauren's attendance. Helen advised Bethe to leave work issues at work, and not to go there outside the workplace. Bethe said she would."

And then you ask if there is more follow-up I need to do.

11:09:14 1 Why were you reaching out to Ms.
11:09:18 2 MacDonald in this particular case?
11:09:20 3 A. I think I wanted to make her
11:09:21 4 aware of what Beth was saying to me about being
11:09:27 5 gay and if I had covered everything properly,
11:09:32 6 that you know, I hadn't done anything wrong,
11:09:34 7 and if there was any more follow-up that I
11:09:36 8 would need to do on it.
11:09:37 9 Q. And do you know if there was
11:09:39 10 any response from Ms. MacDonald?
11:09:41 11 A. I can't remember, no.
11:09:43 12 Q. And so in this particular
11:09:45 13 situation, you described the discussions with
11:09:50 14 Beth Wettlaufer and identifying to her to leave
11:09:53 15 issues at work as being a counselling session;
11:09:55 16 correct?
11:09:56 17 A. I would believe so, yes.
11:09:57 18 Q. Now there is -- before we
11:10:00 19 leave this particular section, there is one
11:10:02 20 document that's located -- that was located
11:10:06 21 within the file to which there did not appear
11:10:09 22 to be any discipline associated with it, and in
11:10:13 23 fact, I believe it has some comments on the
11:10:16 24 bottom.
11:10:17 25 So if I could turn you,
11:10:19 26 Commissioner, to Exhibit "I" to Ms. Van
11:10:25 27 Quaethem's affidavit and that is document
11:10:28 28 number 16841. Now, this is an email directed
11:10:51 29 to Mrs. Crombez and copying you regarding Beth
11:10:58 30 Wettlaufer?
11:11:00 31 A. Yes.
11:11:01 32 Q. And it relates to how a

11:11:03 narcotic count was being handled on the night
11:11:05 shift, and some interactions between Ms.
11:11:10 Wettlaufer and this particular employee as to
11:11:15 when he should or shouldn't come and help with
11:11:16 the narcotic count.
11:11:18 And if you go down to two thirds
11:11:25 of the way through that first paragraph, you
11:11:29 will see:
11:11:31 "[...] Beth came to me and asked
11:11:32 why [...]"
11:11:39 "Later in the day, when I was
11:11:40 talking to Laura Long regarding
11:11:42 some work, Beth came to me and
11:11:45 asked why [...]"
11:11:46 Can you highlight the rest of
11:11:48 that paragraph? So go up to "Later in the
11:11:57 day", there, right there, and highlight that
11:12:00 particular part from there. And then keep
11:12:09 going down to the end of the document. So it
11:12:18 says here:
11:12:20 "Later in the day, when I was
11:12:21 talking to Laura Long regarding
11:12:23 some work, Beth came to me and
11:12:24 asked why I was not there to
11:12:33 count again. I told her that I
11:12:36 was waiting for her at 0430.
11:12:39 She said, I was in the lounge
11:12:41 and you should have called my
11:12:42 name. Now I thought it was the
11:12:46 time to speak up and made it
11:12:47 very clear to her that I will
11:12:49 not be coming for count anymore

and it is not my job. Moreover, I was not sure if the ministry and management will accept this arrangement.

I started walking away. She said, 'you are angry at me that is why you are walking away.' I said, I am not but do not want to argue in the hallway, in front of residents and staff. She said, 'I am your boss. You need to come if I asked you to come. You are not doing any favor but it is part of your job', and she walked away this time."

And my understanding, just to break here, Brenda, is that at this point in time, 0430, Beth would have been the charge nurse on duty at the time; is that correct?

A. Yes.

Q. She then goes on to say -- he then goes on to say:

"Helen, I find it hard to do my job with this kind of treatment. I feel that I am sandwiched (getting blamed from both sides - top and bottom). I was told that I am responsible for Section A. It is not that I have nothing to do on section A, but I do not take my break and

11:13:56 1 have to rush if I have to help
11:13:58 2 them with a count. I have to do
11:14:00 3 the call-in, give suppositories
11:14:03 4 for both floors, treatment for
11:14:05 5 both floors and morning MEDs,
11:14:08 6 charting, medication scanning,
11:14:10 7 filling up the cart with
11:14:12 8 medications and other necessary
11:14:13 9 equipments, checking expiry,
11:14:15 10 preparing bowel sheets, locking
11:14:17 11 doors, doctor order processing,
11:14:18 12 quarterly MDS assessment,
11:14:22 13 assessing residents and giving
11:14:26 14 p.m. MEDs etc. If Beth is
11:14:27 15 thinking that I have less work,
11:14:28 16 then, something is seriously
11:14:30 17 wrong with the way I work
11:14:31 18 because I don't find the time to
11:14:33 19 take break. I am already
11:14:35 20 running enough between two
11:14:37 21 floors and don't want to do it
11:14:39 22 in B side as well."
11:14:41 23 "B side" is one of the sections
11:14:43 24 of Caressant Care; is that correct?
11:14:46 25 A. Yes, we divided it into A and
11:14:48 26 B.
11:14:48 27 Q. Okay. A and B or Level 1,
11:14:52 28 Level 2 and Section B?
11:14:54 29 A. Level A -- or Section A is
11:14:57 30 Level 1 and 2, and Section B is the older
11:15:02 31 section of the facility.
11:15:05 32 Q. Thank you.

"I have no problem with other two RN's in the night. No one asked me not to interrupt their break and gave me the time-frame to come to narcotic count."

Now, there is handwriting on the bottom of this document. Do you recognize that?

A. Yes, it is my handwriting.

Q. What does it say?

A. "Manju's email", I think, and "did not want action taken."

Q. Now, we haven't located that particular email, but did you take any action despite what this particular employee said?

A. I don't recollect taking any action myself.

Q. Would it not be your responsibility to address these issues rather than simply going by the wishes of the employee?

A. Yes, but I don't want to surmise, but I do think that there was things done.

Q. All right, and in particular, to address -- it appears the issue was with the narcotic count, and this particular employee says:

"I was not sure if the ministry and management will accept this arrangement."

A. No, and I think that Helen

addressed that issue.
Q. All right, were you involved in any way in addressing that issue?
A. Not that I can recollect.
Q. And did that issue involve in any way the disciplining of Elizabeth Wettlaufer from your review of the documents?
A. I can't recall if we disciplined her on this.
Q. Okay, thank you.
Now, we are going to get into a totally different section, Commissioner. Would you like me to start? Would you like to take the morning break? I'm in your hands.
THE COMMISSIONER: I think it would be an appropriate time to take the morning break.
-- RECESSED AT 11:17 A.M.
-- RESUMED AT 11:35 A.M.
BY MS. HEWITT:
Q. Thank you, Commissioner.
As I indicated before we broke, I was ending at a particular spot and that was related to comments and conduct, and I would like now, Brenda, to turn your attention to her work performance other than medications.
And the appropriate paragraphs, Commissioner, in respect of this section of my questioning is paragraphs 67 to 114 of the affidavit, so quite extensive.
And if I can turn first, Amanda, back to the affidavit to paragraph 68, which I

11:37:15 1 believe will be on page 15.
11:37:36 2 So paragraph 58, Brenda,
11:37:40 3 indicates -- sorry, 68, indicates that there
11:37:43 4 were a number of issues that you dealt with
11:37:48 5 during the periods February 2011 to November of
11:37:52 6 2013, and it again provides a summary of how
11:37:56 7 they were dealt with, ranging between verbal
11:37:59 8 warnings to written warnings, counselling,
11:38:05 9 verbal warnings, written warnings, et cetera.
11:38:08 10 So I do want to take you again
11:38:11 11 and spend some time on these particular issues.
11:38:14 12 This will be a bit different, though, so I
11:38:19 13 would like you to just take a moment. The
11:38:20 14 documents that I will take you to and you to,
11:38:23 15 Commissioner, involve residents, incidents with
11:38:27 16 residents a lot of them, and we have undertaken
11:38:30 17 not to say the resident's name. And I know you
11:38:33 18 know these residents very well. I know them
11:38:35 19 very well in terms of having read the
11:38:37 20 underlying document. But we need to be very
11:38:41 21 careful. I would rather just in each section
11:38:45 22 talk about a resident or perhaps his or her
11:38:47 23 initials.
11:38:48 24 So again, that may take some
11:38:51 25 doing, but just take your time before you
11:38:53 26 answer and formulate how you are going to
11:38:55 27 answer without using the actual resident's
11:38:58 28 name.
11:38:59 29 A. Yes.
11:38:59 30 Q. Okay. Now, the first one,
11:39:01 31 I'm not going to take you to it, is dated
11:39:04 32 February 8th, 2011, with a verbal warning. And

11:39:08 that involves Commissioner, the RAI/MDS system
11:39:17 and whether Elizabeth Wettlaufer was doing
11:39:18 treatments, et cetera. I'm leaving those
11:39:21 questions related to that particular discipline
11:39:24 to Mrs. Crombez, and so I'm going to start on
11:39:26 the second document, the second section, which
11:39:33 is in respect of -- sorry, the third section,
11:39:38 which is counselling.
11:39:39 It is a little -- the section is
11:39:42 a little difficult, but I want to start,
11:39:46 Commissioner and Brenda, with issues that arose
11:39:50 between Elizabeth Wettlaufer and a female
11:39:53 resident at Caressant Care starting in January
11:39:56 of 2012 and ending in February of 2012 in terms
11:40:03 of those residents.
11:40:04 Now, do you recall the incidents
11:40:06 to which I am referring?
11:40:07 A. Yes, I do.
11:40:08 Q. So if you can just speak up a
11:40:10 bit as well, Brenda.
11:40:12 Now, I'm going to go to an
11:40:19 exhibit in a minute, but tell me a bit about
11:40:22 any relationship that you or Ms. Crombez had
11:40:25 with this particular resident. Set the scene
11:40:29 for us.
11:40:30 A. This resident was a younger
11:40:31 resident. I would say she was in her 50s. And
11:40:42 I could be wrong on that, but she was a younger
11:40:45 resident. She had lived for a period of time,
11:40:52 prior to me working in the home, in the
11:40:56 retirement home. I think then she left the
11:41:01 retirement home, went into the community. She

11:41:04 1 came -- she was in a group home and eventually
11:41:10 2 she ended up back at Caressant Care, but in the
11:41:14 3 long-term care section.
11:41:16 4 Helen knew her quite well in the
11:41:19 5 retirement home, and this person didn't have a
11:41:25 6 lot of support from her family, and Helen
11:41:32 7 supported her and became like a friend with
11:41:36 8 her. She would, you know, help her with
11:41:45 9 shopping, help her with laundry. She took her
11:41:51 10 -- you know, she did what she could for her.
11:41:56 11 So when I started, this resident
11:42:01 12 only had finances of what the comfort allowance
11:42:05 13 allowed, so her spending money was around
11:42:14 14 120-some dollars a month. She could not handle
11:42:16 15 money at all --
11:42:19 16 Q. And I don't want to get into
11:42:20 17 those particular details --
11:42:21 18 A. Okay.
11:42:22 19 Q. -- about the resident. But
11:42:25 20 if you can leave out some of the more personal
11:42:28 21 type details, what was the resident like?
11:42:32 22 A. Oh, okay, I'm sorry for that.
11:42:36 23 Q. That is okay.
11:42:37 24 A. But she was like a child.
11:42:46 25 She -- I would put her age at anywhere from an
11:42:52 26 8 to a 12 year old. She was a friendly person,
11:43:01 27 strong-willed, liked to have her own way, could
11:43:11 28 be untruthful, but also very caring and
11:43:20 29 pleasant at times, like making little crafts
11:43:23 30 for other people.
11:43:26 31 We had a lot of interaction with
11:43:28 32 her. She needed a lot of love and attention

and she got it from us, from Helen and I and other staff members as well.

Q. So let me stop you there with that bit of background. I'm going to turn the Commissioner to tab K of Exhibit 10, and that is document 00522.

And, Commissioner, what you should have before you is a Critical Incident Report.

THE COMMISSIONER: Yes, thank you, I have that.

BY MS. HEWITT:

Q. So we'll just talk a bit about this document, Brenda. Can you first explain what is a Critical Incident Report?

A. It is a report that is sent to the Ministry of Health and Long-Term Care for reporting abuse, where a resident is sent to hospital with a condition that will affect them. Yeah, it is a report we send to the Ministry.

Q. Now, we talked earlier today about certain instances where you were required to immediately report. Is this the mechanism by which you would report?

A. Yes, yes, it is.

Q. And is this document filled in online or typed and sent to the Ministry?

A. It is filled in online.

Q. And who would be responsible at Caressant Care to filling this document in?

A. It was either Helen or myself

11:45:31 1 that filled them in. Most instances it was
11:45:35 2 Helen that filled them in, but I filled them as
11:45:39 3 well.
11:45:39 4 Q. And at the very top of the
11:45:41 5 document, it identifies "CI date and time,
11:45:45 6 January 12, 2012, 01:30." Am I right in
11:45:50 7 indicating that that is the actual time the
11:45:54 8 incident is said to have occurred?
11:45:56 9 A. CI date and time, yes.
11:45:57 10 Q. And then beside that is "date
11:45:59 11 and time CI first submitted to the Ministry of
11:46:03 12 Health." This particular one states January
11:46:06 13 30th, 2012?
11:46:06 14 A. Yes.
11:46:07 15 Q. And so am I right then in
11:46:10 16 interpreting that as the incident took place on
11:46:13 17 January the 12th and the report was submitted
11:46:17 18 on January the 13th?
11:46:18 19 A. Yes.
11:46:18 20 Q. So let's then go through this
11:46:23 21 particular report in some detail. The
11:46:33 22 description of the incident which occurs
11:46:36 23 halfway down the page there -- Amanda, if you
11:46:40 24 could highlight the description of the incident
11:46:42 25 paragraph. Thank you. And the description of
11:47:01 26 the incident states:
11:47:04 27 "Resident noted to have cold
11:47:06 28 symptoms on evening shift and
11:47:07 29 was reminded by L. Durbidge
11:47:07 30 [...]"
11:47:11 31 And that is another registered
11:47:12 32 staff member, as I understand it; is that

11:47:14 correct?
11:47:14 A. Yes, it is.
11:47:16 "[...] of 5 day isolation
11:47:17 protocol. Resident stated she
11:47:19 would not comply as she had her
11:47:21 brother's birthday party on
11:47:22 Saturday. At 00:30 [...]"
11:47:25 And I understand that to be
11:47:27 12:30 a.m.; is that correct?
11:47:29 A. Yes.
11:47:29 "At 00:30, resident went to
11:47:33 nurses' station. Resident had a
11:47:36 stuffed nose and a hoarse voice.
11:47:38 Replied that she had been
11:47:39 coughing when asked by B.
11:47:41 Wettlaufer, RN. RN asked her to
11:47:44 return to her room as she was
11:47:46 contagious. Resident did so
11:47:48 without incident but came to
11:47:52 desk at 01:15," so again 1:15
11:47:57 a.m., "with her coat on saying
11:47:59 she was leaving facility.
11:48:02 Resident signed herself out and
11:48:04 left the building. Resident
11:48:05 reported to H. Crombez, DON
11:48:07 [...]"
11:48:07 And I understand that to be
11:48:09 Director of Nursing?
11:48:09 A. Yes.
11:48:10 "[...] that B. Wettlaufer, RN
11:48:14 slapped her as she was leaving
11:48:15 the building."

So my understanding of this incident was that that report of Elizabeth Wettlaufer allegedly slapping this resident would have taken place the morning of the incident; is that correct?

A. Yes, at -- yes.

Q. All right, so that is then January 12th, 2012?

A. Yes.

Q. And then if I can just take you to the next page, and if we can scroll down to "Actions taken," and that particular paragraph states:

"Incident investigated immediately. Resident interviewed. [Resident] stated that she was slapped when telling me. During our discussion B. Van Quaethem asked [Resident] to demonstrate how and where she was hit with the same force as best she could. [Resident] closed her fist and punched Brenda," that would be you, "in the front of her shoulder which indicated her shoulder which had the surgery."

And then some other people are interviewed.

Now, my first question in respect of this, Ms. Van Quaethem, is that the documents indicate that this resident alleged

11:49:44 1 that Elizabeth Wettlaufer slapped her and there
11:49:48 2 was no immediate reporting of this particular
11:49:50 3 situation to the Ministry. So can you explain
11:49:54 4 for us what was happening at this time and why
11:49:58 5 this allegation of a slap from Elizabeth
11:50:02 6 Wettlaufer wouldn't have been immediately
11:50:03 7 reported?
11:50:03 8 A. What was happening at the
11:50:07 9 time was that this resident was in one of her
11:50:14 10 stages where she was going to do what she was
11:50:17 11 going to do. She knew by leaving at 1:30 in
11:50:22 12 the morning that she would be in trouble with
11:50:27 13 Helen and myself, because, you know, it is
11:50:31 14 unsafe to be out there for a woman at 1:30 in
11:50:34 15 the morning.
11:50:35 16 We did not report it because we
11:50:40 17 knew this resident well and we knew she was
11:50:42 18 lying.
11:50:44 19 Q. Let me just take you back to
11:50:47 20 that the resident would be in trouble with you
11:50:49 21 and Helen for leaving. Is this not her home?
11:50:52 22 Can she not leave? What do you mean --
11:50:54 23 A. They can leave. They can
11:50:55 24 leave. You know, they can sign the book and
11:50:59 25 leave, but she would know that, you know, we
11:51:07 26 would say to her - and I can't say the name -
11:51:10 27 but we would say her name and say, why did you
11:51:13 28 do this? You know, we treated her as one of
11:51:19 29 our children. I would talk to my children that
11:51:21 30 way if they went out at 1:30 in the morning.
11:51:25 31 Q. So that is what you mean by
11:51:27 32 "in trouble"?

11:51:28 A. Yes. And so --
11:51:32 Q. All right. And so at that
11:51:34 point in time, you indicate that you didn't
11:51:37 believe that this had happened the way she had
11:51:39 indicated?
11:51:39 A. No, not at all.
11:51:41 Q. And then at the next page, if
11:51:46 we can just scroll down, under "What is the
11:51:52 outcome/current status of the individual who
11:51:55 was involved in this occurrence?" it states:
11:51:59 "Resident came to my office
11:52:01 January 16, 2012, with B.
11:52:03 Wettlaufer, RN and said that she
11:52:05 came to apologize as RN did not
11:52:07 hit her. B. Wettlaufer thanked
11:52:09 her and recognized that this was
11:52:11 a difficult thing for [Resident]
11:52:13 to do."
11:52:13 So by January 16th this
11:52:19 particular resident had come in with Bethe
11:52:22 Wettlaufer and had apologized and said it
11:52:24 didn't happen; is that correct?
11:52:25 A. Yes.
11:52:25 Q. Did you at the time turn your
11:52:33 mind to the fact that the resident could have
11:52:35 been influenced by Bethe Wettlaufer to come and
11:52:37 apologize? Did that cross your mind, was it a
11:52:39 consideration?
11:52:40 A. I don't believe that that
11:52:41 crossed my mind at all at that time.
11:52:43 Q. Would you -- was this
11:52:44 particular resident vulnerable to that

11:52:46 1 particular type of situation, or do you know,
11:52:50 2 in terms of being intimidated by anyone?
11:52:53 3 A. No, I don't believe that she
11:52:56 4 would be intimidated. I think she would -- she
11:53:01 5 could stick up for herself.
11:53:02 6 Q. But, in any event, that never
11:53:04 7 crossed your mind that there may be --
11:53:06 8 A. No, it did not cross my mind
11:53:08 9 that she was intimidated by Bethe.
11:53:10 10 Q. No, I want to go back to this
11:53:11 11 reporting to the Ministry, and the reason I
11:53:14 12 want to do it is to say who -- what is your
11:53:18 13 understanding in terms of your reporting
11:53:21 14 obligations? Because here you have someone
11:53:24 15 that reports that they have been slapped. You
11:53:30 16 do your investigation and you do not believe
11:53:34 17 it.
11:53:34 18 But is there still not a
11:53:35 19 reporting obligation to the Ministry so that
11:53:37 20 they can have an oversight of this particular
11:53:40 21 situation?
11:53:40 22 A. I think at the time I felt
11:53:45 23 that we were handling the situation, because we
11:53:53 24 did not believe that the incident occurred. In
11:53:56 25 hindsight, yes, it would have been probably
11:54:00 26 best just to report it and let the Ministry do
11:54:03 27 the investigation.
11:54:03 28 Q. Or both of you?
11:54:05 29 A. Uhm-hmm.
11:54:06 30 Q. Is there --
11:54:07 31 A. Yes.
11:54:07 32 Q. Are there supposed to be

11:54:09 1 concurrent investigations, one that you do
11:54:11 2 internally to deal with a situation and
11:54:13 3 potential discipline and one that is external
11:54:16 4 with these types of allegations with the
11:54:18 5 Ministry?
11:54:18 6 A. I would believe that the
11:54:20 7 Ministry would come in and do their own
11:54:23 8 investigation, yes, and we would do our own.
11:54:25 9 Q. Now, in this particular
11:54:28 10 situation, we understand, and it is actually
11:54:31 11 noted in your document here, that the resident
11:54:35 12 herself called the Ministry of Health on
11:54:37 13 January 23rd, 2013, to report that she had been
11:54:42 14 slapped. June Osbourn, and I understand that
11:54:46 15 is a Ministry employee, called and spoke with
11:54:49 16 J. Lowe, Assistant Director of Nursing, January
11:54:53 17 24, 2012.
11:54:54 18 So at that point in time, as I
11:54:56 19 understand the document to read, Caressant Care
11:54:58 20 was alerted to the fact that the resident
11:55:01 21 hadn't let this go; she had actually reported
11:55:04 22 the situation to the Ministry?
11:55:05 23 A. Yes.
11:55:06 24 Q. Now, that takes place on
11:55:10 25 January 24th, 2002, and yet the incident report
11:55:15 26 is not filed until January 30th of that year.
11:55:17 27 Do you know why there was then a six-day delay
11:55:21 28 in actually putting this particular Critical
11:55:27 29 Incident Report in?
11:55:28 30 A. No, I do not.
11:55:29 31 Q. Okay. Now, there is -- let's
11:55:33 32 go to this "Analysis and follow-up." And

11:55:37 1 again, this is -- as I understand this
11:55:39 2 document, you are implementing these things as
11:55:44 3 they arise, and is that why the term "amended"
11:55:48 4 comes up on the top right-hand side of these
11:55:50 5 documents?
11:55:51 6 A. Yes.
11:55:51 7 Q. Okay. So we do now see some
11:55:55 8 additional information that is beyond the
11:55:57 9 initial date that you reported it, and it says:
11:56:01 10 "What immediate actions have
11:56:03 11 been taken to prevent
11:56:05 12 recurrence?
11:56:05 13 Prompt investigation of any
11:56:06 14 reports of abuse."
11:56:07 15 And so what does that mean?
11:56:10 16 Where would you get that particular information
11:56:12 17 from?
11:56:13 18 A. I don't know where we got it
11:56:18 19 from.
11:56:19 20 Q. Would that have been
11:56:20 21 something that the Ministry reminded you of?
11:56:22 22 A. It very well could have been.
11:56:26 23 Q. It says:
11:56:27 24 "Police were called [...]"
11:56:29 25 Sorry?
11:56:29 26 A. I was just going to say I
11:56:31 27 don't recall that clearly at that time.
11:56:32 28 Q. Thank you. It goes on to
11:56:36 29 say:
11:56:37 30 "Police were called and
11:56:38 31 investigated on February 8, 2012
11:56:40 32 the incident with [the Resident]

reporting she was hit by the RN. The police officer informed [the Resident] if she was lying that she could be charged. [The Resident] said she understood this."

Now, I want to stop there because my understanding, and I will take you to the document in a minute, Commissioner, is that the February 8th, 2012 incident there, that was a separate allegation of slapping; is that correct?

A. Yes, it was.

Q. All right. And so if we can just -- I know this is difficult, Commissioner, but it is important to get the sequence of events right. If I can turn you to document 00389, which appears at Exhibit L to the affidavit of Brenda Van Quaethem. That was fast, thank you.

This is a Critical Incident Report, as I understand it. The alleged incident, if we are reading at the top, is February 8th, 2012, 06:30, that is the date the incident occurred or was reported to you as having occurred?

A. That is when it occurred.

Q. And the date that Caressant Care submitted this Critical Incident Report is that same day by 11:52 a.m.?

A. Correct.

Q. And if we go down to the

description of the incident:

"Resident states she was sleeping in her bed. Resident states B. Wettlaufer, RN came into her room and hit her on her left frontal shoulder to wake her up to do her blood sugar."

So in this particular situation, there is an allegation that this resident was hit and that particular day you did advise the Ministry of same; is that correct?

A. Correct.

Q. Now, in respect of this incident of February 8th, we do see on the next page "Actions taken," and it states:

"Resident reported to the Administrator that she was hit this morning.

B. Van Quaethem and H. Crombez met with [Resident], was asked for the details of the incident.

B. Van Quaethem reported the incident to head office. H. Crombez called L.S. sister and POA and left a message asking her to call the home. Police were called and notified of the incident."

So that then, when I was reading that in the other Critical Incident Report, that is what you are referring to as the visit from the police; is that correct?

11:59:43 A. I believe so, yes.
11:59:44 Q. Okay, and so when the police
11:59:46 actually come in the other Critical Incident
11:59:51 Report, they tell this particular resident that
11:59:54 if she is lying, she could be charged. She
11:59:57 said she apologized to this.
12:00:08 Now, I'm sorry to do this,
12:00:08 Commissioner, but can we go back then to
12:00:09 document number 00522. Now, if we can go to
12:00:28 page 3 of that document, the line that says
12:00:37 "February 16, 2012." Do you see that right
12:00:42 under "Analysis and follow-up"?
12:00:44 A. Yes.
12:00:45 Q. It says:
12:00:46 "February 16, 2012 [Resident]
12:00:48 was rude to Bethe Wettlaufer.
12:00:54 [Resident] later apologized for
12:00:56 her behaviour to Bethe."
12:00:57 So I didn't ask you about the
12:00:58 February 8th incident. Did you believe that
12:01:01 that had happened?
12:01:02 A. No, I did not.
12:01:03 Q. But in any event, you did
12:01:05 submit that to the Ministry?
12:01:08 A. Yes, I did.
12:01:08 Q. And in respect of this
12:01:09 particular situation, you reported an ongoing
12:01:12 issue between the resident and Bethe
12:01:14 Wettlaufer, and again the resident apologizing;
12:01:19 is that correct?
12:01:19 A. Yes, that is what -- I am not
12:01:22 recollecting it, but yes, I do.

12:01:26 Q. Now, I want to take you to
12:01:36 document number 16840, which is Exhibit M to
12:01:41 your affidavit.
12:01:45 A. Yes.
12:01:45 Q. This document, when we get to
12:01:50 it, is dated February 22nd, 2012, and it, as I
12:01:59 understand it, purports to be a Discipline
12:02:01 Action Form where you would identify to an
12:02:04 employee that they were being disciplined; is
12:02:06 that correct?
12:02:06 A. Yes.
12:02:10 Q. It states on this form "Date
12:02:13 incident occurred," February 16th, 2012. The
12:02:15 actual date of the form is February 22nd, 2012.
12:02:18 That date of February 22nd, what does that
12:02:21 refer to?
12:02:21 A. That is -- the date of
12:02:24 February 22nd is the date that we gave that
12:02:26 employee the discipline.
12:02:28 Q. Okay. And at the bottom it
12:02:31 has "Signature of immediate supervisor," and is
12:02:36 that Helen Crombez's signature?
12:02:38 A. Yes, it is.
12:02:38 Q. And under "Present,"
12:02:40 yourself?
12:02:41 A. Yes.
12:02:41 Q. And then Elizabeth Wettlaufer
12:02:43 would have had Ms. Routledge as a union
12:02:45 representative?
12:02:45 A. Yes.
12:02:45 Q. And this particular incident,
12:02:48 it says:

"Describe the incident in detail - inappropriate conversation with a resident regarding telling her you would not longer stand for being bullied. This is inappropriate as you are the Reg. Staff and need to remain calm and professional at all times."

Do you see that?

A. Yes.

Q. In your affidavit at paragraph 80 you talk about this particular incident.

A. Okay.

Q. And you say:

"I don't have a clear recollection of this, but I believe that Elizabeth Wettlaufer may have said something to this same resident about not wanting to be bullied."

And so my understanding from that, Brenda, is that it is the same resident we have been talking about and for which there has been critical incidents submitted?

A. I believe that as well.

Q. That having been said, while in the Critical Incident Report you report what the resident said to Elizabeth Wettlaufer --

A. Yes.

12:04:08 Q. -- you don't report -- and, sorry, just for your ability, it is at tab K.
12:04:17 A. Yes.
12:04:17 Q. Document 00522. You don't report this incident of Elizabeth Wettlaufer making a comment to the resident. Why wouldn't that be included to give context to what was going on at the time?
12:04:36 A. Well, I don't know.
12:04:43 Q. Should it have been included?
12:04:44 A. Yes, if it all occurred, which I think, from the looks of this, it all occurred on February 16th, but Helen filled in the critical incident. Was she aware that that was -- I can only surmise that --
12:05:06 Q. Well, we are going to talk to Helen.
12:05:08 A. Okay.
12:05:09 Q. So she filled in this report?
12:05:11 A. Uhm-hmm.
12:05:11 Q. Is that correct?
12:05:12 A. Yes.
12:05:12 Q. And you are indicating that you don't know at what time she became aware --
12:05:18 A. No.
12:05:19 Q. -- of the subsequent incident? Would you have been able to amend, though? We have seen some amendments. Would you have been able to amend to add that particular issue once you became aware?
12:05:28 A. Yes, yes, we could.
12:05:29 Q. And as far as I am aware,

12:05:32 this is the finalized document, so that
12:05:36 amendment was not made. Do you know of any
12:05:40 further --
12:05:40 A. I don't know of any further,
12:05:42 no.
12:05:42 Q. Okay. Now, if we can go
12:05:47 back, Amanda, to 00522, and if we can go to
12:06:15 page number 3 and begin again picking up the
12:06:19 "Analysis and follow-up." So we have talked
12:06:27 about the February 16th, 2012 incident, and it
12:06:32 goes on to state:
12:06:34 "February 24, 2012, a family
12:06:36 meeting was held with [the POA
12:06:41 and sister, a niece, Elizabeth,
12:06:44 Helen, yourself] to discuss
12:06:46 recent behaviour. [They] both
12:06:51 apologized," it appears, "to
12:06:52 each other. Goals were set for
12:06:54 [the Resident] with her input.
12:06:55 [The Resident] was happy and
12:06:57 relaxed after the meeting.
12:07:00 After family members left and
12:07:02 [Bethe] left, [the Resident]
12:07:03 [actually] came to the office
12:07:05 and asked if the Ministry could
12:07:07 be called and asked not to come
12:07:09 in. In questioning as to why,
12:07:13 [the Resident] said the police
12:07:15 lady said if I lied I will go to
12:07:18 jail. [Resident] was reassured
12:07:19 that we recognized that she was
12:07:21 angry and she wanted to get the

RN in trouble."
That would be Bethe Wettlaufer?
A. Yes, it would be.
"It was explained to [the Resident] that the incident was over and she would not be going to jail. It was explained to [the Resident] that she should tell the truth if the Ministry comes in to investigate."
A. Yes, correct.
Q. What was your view of how -- what was the result of this family meeting on February 24th, 2012?
A. I can recollect that we had a family meeting because this resident was no longer happy in long-term care, and I won't say -- you need to talk to Helen about what was all done to arrange that this woman could live independently on her own in the community, which was successful, and I believe to this day she is still in the community.
And when this resident wasn't happy and -- she made up a lot of things, and I never ever believed she was hit. And I felt that after the family meeting, because we had set aside some little goals for her, like, you know, to keep her -- make her happier, because she had conveyed to us what she wasn't happy with in long-term care, I felt, you know, that we were getting to a better place with this resident.

12:09:12 1 And I am not absolutely sure,
12:09:16 2 but I think later that year she was moved to
12:09:18 3 the community.
12:09:21 4 Q. And was there any further
12:09:23 5 contact after she left the long-term care
12:09:28 6 between you and her or between Helen and this
12:09:30 7 particular resident?
12:09:31 8 A. She would come by my office
12:09:33 9 and visit me, and with Helen she stayed in
12:09:40 10 closer contact. She had Helen visit her
12:09:44 11 apartment. She -- yeah, she stayed in closer
12:09:47 12 contact with Helen.
12:09:48 13 Q. And did the resident with you
12:09:54 14 ever raise the issues that are referred to in
12:09:57 15 the two Critical Incident Reports that we are
12:10:01 16 talking about?
12:10:01 17 A. Are you meaning afterwards?
12:10:04 18 Q. Yes.
12:10:04 19 A. No, not to my recollection,
12:10:06 20 no.
12:10:06 21 Q. And I won't turn you,
12:10:11 22 Commissioner, but there is a Progress Note as
12:10:14 23 well referred to at paragraph 81 of the
12:10:20 24 affidavit, Exhibit N, that again reflects the
12:10:24 25 outcome of the family meeting.
12:10:26 26 So now this is part of what you
12:10:31 27 were dealing with, with Elizabeth Wettlaufer in
12:10:34 28 January and February of 2012?
12:10:37 29 A. Yes.
12:10:37 30 Q. But it does appear that other
12:10:40 31 issues were arising at the same time; would you
12:10:43 32 agree with that? Do you recall there being --

12:10:48 1 before we are going to get into it, I just want
12:10:50 2 to know whether you recall other issues?
12:10:52 3 A. Not off the top of my head,
12:10:55 4 no.
12:10:55 5 Q. So we are going to work
12:10:56 6 backwards for a moment on this, and I want to
12:10:58 7 turn you to Exhibit R -- sorry, Exhibit S of
12:11:07 8 your affidavit, which is document 16842. Do
12:11:23 9 you see that document?
12:11:24 10 A. Yes.
12:11:25 11 Q. And this purports to be
12:11:32 12 discipline given to Bethe Wettlaufer on January
12:11:36 13 16, 2012; do I have that right?
12:11:38 14 A. Yes.
12:11:39 15 Q. And it is signed by yourself?
12:11:43 16 A. Can I correct that?
12:11:44 17 Q. Yes.
12:11:45 18 A. Can you just repeat what you
12:11:46 19 just said to me?
12:11:47 20 Q. It looks like the discipline
12:11:50 21 would have been given to Ms. Wettlaufer on
12:11:53 22 January 16th, 2012?
12:11:55 23 A. Yes, yes, that is correct.
12:11:56 24 Q. It identifies again Helen
12:12:02 25 Crombez, yourself and Karen Routledge as being
12:12:06 26 a part of this?
12:12:07 27 A. Correct.
12:12:08 28 Q. And the incident is described
12:12:11 29 as "Various," and in detail it states:
12:12:16 30 "Not meeting the required needs
12:12:18 31 of residents in a timely manner,
12:12:21 32 and not following policy and

12:12:22 1 procedure after a fall."
12:12:24 2 Do you see that?
12:12:25 3 A. Yes, I do.
12:12:26 4 Q. Now, I'm going to take you
12:12:28 5 through these documents, but there appears to
12:12:33 6 have been a number of staff members that came
12:12:36 7 forward in January 2012 with issues related to
12:12:41 8 Elizabeth Wettlaufer and that this was the
12:12:46 9 discipline as a result; is that your
12:12:47 10 recollection?
12:12:48 11 A. I believe so, yes.
12:12:50 12 Q. All right. So I just wanted
12:12:51 13 to set up, first of all, that there was a
12:12:55 14 discipline on January 16th, 2012, for various
12:12:58 15 issues that came forward regarding not meeting
12:13:02 16 the needs of a resident.
12:13:04 17 And so I want then to take some
12:13:07 18 time to review these particular issues.
12:13:11 19 So if I can first refer to
12:13:15 20 document 16848, and, Ms. Van Quaethem, your
12:13:26 21 affidavit, paragraphs 84 and 85 refer to this
12:13:36 22 particular incident, and, Commissioner, it is
12:13:43 23 at Exhibit Q.
12:13:58 24 Now, this document is in
12:14:01 25 handwriting. It is signed by Ms. Pike. Is
12:14:07 26 that an employee of Caressant Care?
12:14:09 27 A. Yes, a PSW.
12:14:10 28 Q. A PSW. And it is dated
12:14:13 29 December 16th, and yet it appears to be "11."
12:14:21 30 Do you see that on the top? On the top
12:14:26 31 right-hand side?
12:14:27 32 A. Yes, I do, I do see that.

12:14:30 Q. Now, just before we get any
12:14:32 further, one thing I do want to note, for
12:14:34 yourself as well, Commissioner, is that the
12:14:35 second page of this document, when it starts
12:14:39 "On another occasion [...]," it states:
12:14:43 "On another occasion in the week
12:14:44 of January 2-8 [...]"
12:14:49 So at this point in time, we
12:14:52 haven't been able to identify the specific time
12:14:54 that this letter was written, although the top
12:14:57 says December 16th, it was received in January
12:15:03 by Ms. Crombez and you will hear that from her.
12:15:08 THE COMMISSIONER: All right,
12:15:09 thank you.
12:15:09 BY MS. HEWITT:
12:15:09 Q. And I am going to read some
12:15:10 of these documents, Brenda. This one states:
12:15:12 "I think it is my job as a care
12:15:15 provider at CCNRH," and that
12:15:19 would be Caressant Care Nursing
12:15:20 and Retirement Home, "to bring a
12:15:23 few things to your attention
12:15:25 regarding a head nurse 'Beth'.
12:15:31 On the nights of December 5, 6
12:15:34 and 7, while doing rounds I had
12:15:39 noticed [Resident] VT having
12:15:42 difficulty breathing. It was
12:15:45 very shallow, quick and raspy.
12:15:49 Immediately after leaving the
12:15:51 resident's room I went to Beth
12:15:54 the head nurse in charge. On
12:15:57 all three nights 'Beth' told me

12:15:59 1 that resident is COPD [...]"
12:16:04 2 And do you know what COPD means,
12:16:07 3 Brenda?
12:16:07 4 A. I --
12:16:10 5 Q. If you are going to guess,
12:16:11 6 we'll ask Mrs. Crombez, that is not a problem.
12:16:13 7 A. Yes, ask Mrs. Crombez for the
12:16:15 8 right name. Something to do with your
12:16:19 9 breathing or lungs.
12:16:20 10 Q. Yes, I believe it is to do
12:16:21 11 with breathing.
12:16:29 12 "On all three nights 'Beth' told
12:16:31 13 me that resident is COPD 'I
12:16:34 14 think' and went about her
12:16:36 15 business. On the night of
12:16:37 16 December 8 while working with D
12:16:40 17 we checked on [Resident] V and D
12:16:45 18 saw the same symptoms I reported
12:16:47 19 the last three days prior. I
12:16:49 20 then explained the situation to
12:16:51 21 D and she reported to Beth. It
12:16:55 22 was at that time that Beth
12:16:57 23 decided to check on resident.
12:16:59 24 Beth after checking resident
12:17:02 25 decided that V was COPD level 2
12:17:05 26 and gathered an oxygen machine
12:17:07 27 for resident.
12:17:09 28 I feel that V was neglected by
12:17:11 29 Beth and suffered for three days
12:17:14 30 with shortness of breath and
12:17:16 31 laboured breathing. I feel this
12:17:19 32 could have been prevented if

12:17:20 Beth was doing her job
12:17:22 correctly.
12:17:24 On another occasion the date of
12:17:26 December 5th Resident G started
12:17:30 ringing at around 2:25 a.m. I
12:17:34 approached Beth where she was
12:17:36 found sleeping in the chapel to
12:17:39 tell her that G wanted some pain
12:17:42 meds. She told me it would have
12:17:45 to wait until 3 a.m. when she
12:17:48 was finished her break. This
12:17:50 meant that G would have to be
12:17:52 uncomfortable for at least an
12:17:53 hour until her meds would even
12:17:56 become in effect.
12:17:59 On another occasion in the week
12:18:01 of January 2-8 I recall G
12:18:05 started ringing her bell around
12:18:08 2:15 a.m. for her Ativan
12:18:17 (sleeping aid). Beth was
12:18:19 approached on her break in
12:18:21 regards to this. I was told she
12:18:23 would get it shortly. G had
12:18:28 rang x 2 again. G finally rang
12:18:32 again for the last time at 3:45
12:18:34 because she said she wanted her
12:18:36 Ativan and if she was not going
12:18:38 to get it to just tell her she
12:18:42 can't have it because she had
12:18:43 been waiting a long time and
12:18:45 can't sleep. G was very upset
12:18:48 about this, and wanted an

12:18:50 1 explanation.
12:18:51 2 These are three specific
12:18:53 3 occurrences that have been very
12:18:56 4 bothersome to me. As I
12:18:58 5 explained, I knew the right
12:19:02 6 thing to do but was hesitant due
12:19:04 7 to fear. I am not a 'rat' or a
12:19:07 8 'troublemaker' but have known
12:19:10 9 that by not telling anyone, I
12:19:12 10 was only hurting the residents
12:19:14 11 of [Caressant Care Nursing
12:19:17 12 Retirement Home]. I do believe
12:19:19 13 that by telling you of these
12:19:20 14 occasions that it will be
12:19:22 15 properly dealt with and I feel
12:19:23 16 in my heart that now I have done
12:19:26 17 the correct thing by bringing
12:19:27 18 this to your attention."
12:19:29 19 My understanding, Brenda, is
12:19:35 20 that this was one of the issues that you did
12:19:37 21 discipline Bethe for in that verbal warning; is
12:19:40 22 that correct?
12:19:40 23 A. I believe so, yes.
12:19:42 24 Q. Now, I'm going to go to the
12:19:45 25 investigative meeting that I have, and the
12:19:50 26 Ministry or the Ministry's lawyer -- the
12:19:54 27 Ministry lawyer from the Commission can correct
12:19:56 28 me if I'm wrong, but I don't believe that there
12:20:00 29 was a Critical Incident Report filed in respect
12:20:03 30 of this particular allegation. Are you aware
12:20:07 31 of any Critical Incident Report?
12:20:09 32 A. No, I am not.

12:20:12 Q. So my question is, this PSW
12:20:17 has come forward and actually used the words
12:20:20 "neglect" and identified someone that allegedly
12:20:26 had their COP level properly checked and had
12:20:32 identified that Elizabeth Wettlaufer was
12:20:35 waiting until her breaks had finished to go and
12:20:39 give residents pain or sleeping medications.
12:20:42 So why wouldn't that be
12:20:44 classified as something that should have been
12:20:47 reported to the Ministry immediately?
12:20:49 A. I can't answer you on that,
12:20:57 Liz.
12:20:58 Q. All right. Now, you did
12:21:03 interview Bethe Wettlaufer on these issues, and
12:21:10 my understanding of your affidavit is that you
12:21:12 actually were hearing of these issues and some
12:21:16 of the other ones before they were presented to
12:21:18 you in writing because some of these issues
12:21:21 arose after January 16th but are referred to in
12:21:25 a meeting that you had with Bethe on January
12:21:27 the 12th. Do you know, were you getting verbal
12:21:32 reports at that point in time and then they
12:21:35 were followed up by these written statements
12:21:36 from the employees?
12:21:37 A. I don't recall. Possibly.
12:21:42 Q. Okay. Your notes in respect
12:21:48 -- actually, I am not going to take you there.
12:21:51 I'm going to take you through the rest of the
12:21:53 incidents, and then I'll take you to the
12:21:55 meeting that you had with Bethe.
12:21:56 So let's go to the next
12:21:58 situation that was raised on this particular

12:22:02 1 occasion, and that is reflected in paragraph 86
12:22:08 2 of your affidavit. And, Commissioner, that is
12:22:14 3 at Exhibit R, document 16843.
12:22:26 4 Now, this particular note was
12:22:36 5 written by Wendy MacKnott. And, Commissioner,
12:22:43 6 you'll hear from Ms. MacKnott herself during
12:22:47 7 these proceedings as to what had happened and
12:22:50 8 her view of Elizabeth Wettlaufer's actions.
12:22:52 9 But for now, if I can just -- again, I know it
12:22:56 10 takes a long time, but I think these documents
12:22:58 11 are important to read. If I can just read to
12:23:00 12 you:
12:23:02 13 "My concerns with the shift on
12:23:04 14 Thursday, January 12, 2012.
12:23:08 15 Resident," and again that has
12:23:11 16 been removed, "was up to
12:23:14 17 washroom at approximately 11:05
12:23:17 18 p.m., back to bed right after
12:23:19 19 and settled into her bed.
12:23:22 20 We worked short so as always we
12:23:29 21 all work together to do rounds.
12:23:30 22 First rounds were started at
12:23:32 23 approximately 12:30 after
12:23:35 24 laundry was gathered from R.H.
12:23:38 25 and chairs were cleaned and
12:23:41 26 report was completed."
12:23:42 27 Now, I would just ask you again,
12:23:47 28 Brenda, Wendy MacKnott, was she a registered
12:23:52 29 staff or PSW?
12:23:53 30 A. A PSW.
12:23:54 31 Q. Okay, so this is another PSW
12:23:56 32 that is coming forward at the time:

"Resident in room [blank] A was asleep in her bed as we started rounds on east wing. We continued with rounds and bells finishing rounds at approximately 2:05 a.m. Breaks were taken, charting was done up to that point [...]"

Am I going okay for you?

"[...] up to that point of 3:00 a.m. We started rounds on east at 3:05 a.m. Resident A was found sitting on the floor between bed 1 and 2, blood on floor.

Resident room [blank] was in the washroom, not sure why resident (CH) didn't ring bell to notify staff resident was on the floor. I went down to notify Registered Nurse the resident was on the floor between the beds sitting in blood on the floor. Nurse [...]"

And I believe Ms. MacKnott's evidence will be that this is Bethe Wettlaufer, B.W.

"[...] was in the washroom and stated she would be down as soon as finished. PSWs waited for nurse (Bethe Wettlaufer) to come down while I went to get the mop

and bucket out of housekeeping room.
When I arrived at room, resident was on her bed laying down.
Registered staff was washing A's right leg which had a hematoma on the shin that was tore open.
She also had a hematoma on her left shin that was closed."
So what is a hematoma, do you know that, Brenda?
A. I believe it is like a blood blister, you know, where your skin is rising up and there is blood underneath of it, I believe.
Q. So the resident had an open hematoma on one leg and a closed one on the other, is that your interpretation of this note?
A. Yes.
"After washing resident's right shin registered staff wrapped wound and proceeded to look at left leg. Registered staff stated she suspected resident had broken her hip.
She proceeded to take a pair of small scissors off treatment cart and stated to staff that she was going to pop as she said the hematoma to drain and release pressure. PSW staff just looked at each other as we

didn't feel this was a good thing. Registered staff proceeded to puncture the hematoma and it squirted blood out. Bethe Wettlaufer then proceeded to keep wiping it until the skin was flat on that resident [...]"

Sorry, it looks like there is a page that has been repeated, at least in my copy, Commissioner.

"[...] flat against resident's shin, then dressed wound. PSW continued to wash the blood off resident. After resident was washed and changed myself and Bethe Wettlaufer transferred resident into wheelchair to be transferred to a different room as Bethe Wettlaufer stated she could keep an eye on the resident until ambulance came to take to WGH."

Which I understand is Woodstock General Hospital?

A. Yes.

Q. "PSW stayed behind to continue to clean up floor, strip bed and make sure everything was tidy. I asked PSW if he had helped transfer resident into bed in room

[blank] but he stated no. This could only mean Registered Nurse Elizabeth Wettlaufer must have transferred her by herself. PSW could not understand why if Bethe suspected [Resident] had broken her hip.

Ambulance attendants came to take resident to WGH.

PSW voiced our concerns amongst ourselves and expected management would contact us and they have.

Also that evening, while registered staff Bethe was preparing for resident to transfer to hospital, I asked to check on resident."

And this is the same resident.

"She was calling out and [...]"

Sorry, this is actually a different resident, Commissioner.

"She was calling out and was found holding on to her bed rail stating she was going to fall and I noticed her index finger dripping blood on the floor.

I asked registered staff to look at it and dress it. She stated she would have to do it later, she was busy preparing other resident to transfer to

hospital. Bethe Wettlaufer told me to open treatment cart, take some gauze pads and place them on her finger and she would look at it later, so that is what I did. I do not believe she got there to look at it or dress it properly. It was still the same way at 7:10 a.m. when I went to see how she was.

Please contact me if you have any questions."

And the reason I asked you about the timing is that this note is dated January 15th. It talks about a shift on January 12th and it also talks about the fact that they expected management to talk to them and management has.

So is it your understanding that some of these documents came in after you had already commenced an investigation into these issues?

A. Yeah, I don't know.

Q. You don't know, okay.

A. I do not know.

Q. What is your recollection or do you have any recollection with respect to what is alleged in this particular situation, both in respect of the handling of the one resident and the failure to go back and complete an inspection of the other resident's index finger?

12:30:21 1 A. I believe -- I can't think of
12:30:31 2 my recollection at the time, but I do know that
12:30:36 3 we talked to her about these incidences, and
12:30:40 4 she was just so busy on that shift, she
12:30:43 5 completely forgot about going back to that
12:30:45 6 resident that had hurt her finger.
12:30:48 7 And this resident, I am not sure
12:30:56 8 why she did what she did.
12:30:59 9 Q. Is that a nursing issue?
12:31:00 10 A. It would be a nursing, yes.
12:31:04 11 Q. So would Mrs. Crombez be best
12:31:07 12 in a position to talk about on a nursing side
12:31:09 13 of things whether that hematoma was properly
12:31:12 14 cared for?
12:31:13 15 A. Yes.
12:31:14 16 Q. And in respect of these
12:31:20 17 incidents, did you at any time give any thought
12:31:23 18 as to whether they would meet a threshold level
12:31:26 19 of neglect or abuse?
12:31:28 20 A. Not this incident, I didn't,
12:31:30 21 no.
12:31:31 22 Q. All right. And was this one
12:31:37 23 of the various incidents for which Ms.
12:31:39 24 Wettlaufer received discipline on January 16th?
12:31:42 25 A. Can I just read it?
12:31:52 26 Q. The discipline doesn't
12:31:53 27 actually set out each of the things she is
12:31:56 28 getting disciplined for. It just says
12:32:00 29 "Various." Did you want to see that document
12:32:02 30 again?
12:32:02 31 A. No, I have it in front of me.
12:32:03 32 Q. Okay.

12:32:22 A. I would think so. I would think so.
12:32:27 Q. There was a Critical Incident Report filed in respect of this issue on January 13th, 2012, and it appears that that was in respect of the transfer of the resident to the hospital. Is that a situation under which you have to complete a Critical Incident Report, if a resident has fallen and has been transferred to a hospital?
12:33:05 A. I thought there was another clause in there, if I can refer to that incident reporting.
12:33:16 Q. Yes, I think you are actually right.
12:33:18 A. I think if it was a change in condition, and I do believe that this resident did not break her hip.
12:33:29 Q. All right, maybe we can just turn to the Critical Incident Report, document 17015. It is not appended to your -- Brenda's affidavit, Commissioner, but it is referred to in the Overview Report.
12:34:22 So this is dated January -- I haven't looked at the redactions on this, Commissioner.
12:34:32 Amanda, can you tell me, without scrolling, whether this document has been redacted? There are redactions, thank you.
12:34:41 If we go down to this critical incident, January 13th, 2012, it relates to a fall. If we can keep going, please, under

"Description":

"Found sitting on the floor between her and her roommate's bed. Large amount of blood loss evident on her person and on the floor."

So that is reported. If we can scroll down, "Name of staff responding," it identifies Bethe Wettlaufer and Wendy MacKnott, the PSW, and the other PSW in attendance. It states "Actions taken":

"Head to do revealed 2 lacerations on lower legs. Lower left leg has a 9 cm skin tear and lower right leg has a 4 cm skin tear. Skin tears cleansed with normal saline and pressure dressings applied as wounds were still bleeding. Right foot externally rotated and right hip tender to movement. Resident unable to weight bear on right hip. Resident unable to say what happened and there is a language barrier."

In respect of the smaller tear, do you have any understanding as to whether or not that tear was as a result of the care and treatment that Bethe Wettlaufer had given?

A. Well, I think it is referring to the hematoma, and yes, she did make that one

bleed.

Q. Right. And we will talk to registered staff and Mrs. Crombez as to whether that was appropriate or not. Why -- do you know whether or not that is something that should appropriately be in a Critical Incident Report, that type of detailed nursing care that someone had taken scissors and punctured the hematoma to allow it to bleed and rest against the skin?

A. I would -- you know what, I don't know, but normally we are quite detailed on our critical incidences, what we did. I don't know why that is not in there. I would ask Helen that question.

Q. Yes, that is fine.

And then so this incident is on January -- the shift of January 12th, which extends into the 13th, and then you get this letter from Wendy MacKnott on January 16th. It is written January 15th, and you get it January 16th; is that correct?

A. Correct.

Q. Okay. There is one more incident in this particular range of documents that were coming to you in the beginning of January, Ms. Van Quaethem, or Brenda, and that relates to -- oh, I have lost my place now. Just give me one moment, Commissioner.

THE COMMISSIONER: Yes, of course.

BY MS. HEWITT:

12:38:24 Q. That relates to an incident
12:38:25 that occurred on January 4th, which appears to
12:38:29 have been reported to you on January 14th,
12:38:38 2016, and this incident relates to how Bethe
12:38:43 Wettlaufer was disimpacting a resident. Do you
12:38:48 know what "disimpacting" means?
12:38:52 A. Helping them relieve their
12:38:54 bowels.
12:38:55 Q. All right, so there has been
12:38:56 an issue and this is a process. Now, I'm not
12:38:58 going to take you through that because that is
12:39:01 again more of a nursing situation and I will
12:39:04 take Ms. Crombez through it.
12:39:05 But that appears to be documents
12:39:10 that you were receiving in the beginning of
12:39:12 January, and they are dated -- beginning of
12:39:18 January up until the 15th, and then you
12:39:21 discipline Ms. Wettlaufer on the 16th; correct?
12:39:23 A. Correct.
12:39:24 Q. All right. Now, you did meet
12:39:26 with Ms. Wettlaufer to discuss these issues,
12:39:34 and if I can just turn you to that particular
12:39:38 document, it is dated January the 12th and it
12:39:46 is document 16853.
12:40:03 THE COMMISSIONER: Is this one
12:40:04 in her affidavit?
12:40:05 BY MS. HEWITT:
12:40:05 Q. Yes, it is, sorry,
12:40:06 Commissioner, it is Exhibit O. Have you
12:40:23 located that in your affidavit, Brenda?
12:40:26 A. Just give me a minute.
12:40:29 Q. It should be at Exhibit O.

12:40:31 A. Yes, I have.
12:40:32 Q. Got it? Whose handwriting is
12:40:34 on this document?
12:40:35 A. Mine.
12:40:35 Q. All right. And it is dated
12:40:37 January 12th?
12:40:38 A. Yes.
12:40:38 Q. And it has on the top
12:40:41 right-hand corner "Karen Routledge"?
12:40:43 A. Yes. She would have been in
12:40:46 attendance, I believe, as the union rep.
12:40:50 Q. And do you know who else
12:40:52 would have been in attendance? This document
12:40:56 doesn't have anybody else. Do you know if
12:41:03 Mrs. Crombez would have been here?
12:41:05 A. I believe so, because on page
12:41:09 -- yes, I have "HC" in the margin there, "HC."
12:41:15 Q. On the first page?
12:41:16 A. Yes. I would believe Helen
12:41:19 Crombez is talking and I put her initial there,
12:41:21 that is what she said.
12:41:22 Q. All right. And so if you can
12:41:26 read the document for us and tell us what Helen
12:41:30 Crombez is saying, to the best you can, and
12:41:33 what the explanation that is being given by
12:41:40 Elizabeth Wettlaufer?
12:41:41 A. Okay, in the first paragraph
12:41:46 I believe Helen is saying:
12:41:48 "On your shift fall happened.
12:41:50 Did you complete your work."
12:41:55 I believe Beth would have said:
12:41:57 "Not regarding post fall.

Completed incident report and did not print. Was exhausted, nights, was going."

And she must have said more, but then like as the recorder you don't always keep up, and obviously I didn't go back and fill that in:

"Helen Crombez -- planning to send her to hospital once assessed."

So Helen said something and so I think we are describing the incident with the lady with the hematomas and with the possible hip fracture. And I can't say who would have said "When you send someone to hospital it precludes." I don't know if Helen is talking there or Bethe, I can't say. I would think the next paragraph:

"Blood on floor -- found on floor with [...]"

Q. Let me read it because I -- let me help, only to do the pacing for the transcript.

A. Oh, yes, okay.

Q. So I'll read it a bit: So that next paragraph which starts "Blood on floor," you believe would have been stated by Helen Crombez?

A. It could be Bethe talking as well. I am not sure.

Q. All right. It says:

"We picked her up and put her in

12:43:28 1 bed. Couldn't assess her in the
12:43:30 2 blood. Assessed her skin tears.
12:43:35 3 Took to room [blank] to clean
12:43:37 4 room. Transferred to room
12:43:39 5 [blank]. Leg rotated and in
12:43:46 6 pain, called doctor."
12:43:48 7 Do you know who would have been
12:43:49 8 making those comments?
12:43:51 9 A. Bethe.
12:43:51 10 Q. It says:
12:43:53 11 "Mess, confusion."
12:43:56 12 Do you remember whether or not
12:43:57 13 that was from --
12:43:58 14 A. I don't remember. I would
12:44:00 15 think Bethe, but I don't remember.
12:44:03 16 Q. Okay. And then if I can turn
12:44:06 17 you to the next page, the top of the next page,
12:44:11 18 it talks about:
12:44:15 19 "Her wounds. Washed her legs.
12:44:17 20 Skin tears, hematoma and clots.
12:44:20 21 What did you do with left
12:44:22 22 hematoma. You took what and
12:44:24 23 punctured the skin."
12:44:27 24 And I think that we'll hear from
12:44:29 25 Ms. Crombez, but it appears that the left and
12:44:32 26 right have been perhaps mixed up in this note:
12:44:35 27 "I took scissors and poked at
12:44:37 28 it."
12:44:38 29 Do you know who would have said
12:44:40 30 "I took scissors and poked at it"?
12:44:42 31 A. Bethe.
12:44:44 32 "Were the scissors sterile?

12:44:47 1 No, they were not."
12:44:48 2 Is it safe to say that came from
12:44:50 3 Elizabeth Wettlaufer as well?
12:44:51 4 A. Yes, Helen asked the
12:44:53 5 question, and she responded.
12:44:53 6 Q. And it says:
12:44:55 7 "It would have been appropriate
12:44:56 8 to wash the skin and apply
12:44:58 9 pressure."
12:44:59 10 Is that Ms. Crombez?
12:45:03 11 A. It could be either one of
12:45:04 12 them.
12:45:05 13 Q. Okay. When you are
12:45:07 14 discussing the next resident, it indicates:
12:45:12 15 "What did you do for her?"
12:45:15 16 A. That would be Helen asking.
12:45:16 17 Q. Okay.
12:45:16 18 "Her index finger appeared dark
12:45:19 19 and musty." Or it could be
12:45:22 20 "mushy."
12:45:24 21 "Did you look at it? No, I
12:45:26 22 didn't get to it because of what
12:45:27 23 went on. I did the best I
12:45:30 24 could. In all honesty I
12:45:32 25 forgot."
12:45:34 26 Is that Ms. Wettlaufer speaking?
12:45:36 27 A. Yes.
12:45:39 28 Q. In terms of the incident of
12:45:42 29 disimpacting the resident, it states:
12:45:45 30 "Screaming in agony, more blood
12:45:47 31 in commode than stool."
12:45:49 32 Then it states:

12:45:51 1 "She was uncomfortable, saying
12:45:54 2 Ow, Ow, Ow, but not screaming.
12:45:58 3 Fresh blood from hemorrhoid."
12:46:00 4 A. So I believe Helen said the
12:46:02 5 first two lines, and then I believe Bethe
12:46:07 6 responded she was uncomfortable saying ow, ow,
12:46:10 7 ow, but not screaming, and the fresh blood was
12:46:14 8 from the hemorrhoid.
12:46:16 9 Q. And then it talks about the
12:46:19 10 incidents with respect to the resident that was
12:46:22 11 short of breath. It states:
12:46:25 12 "Eating, not stacking carts,"
12:46:31 13 not stating carts, "resident
12:46:33 14 short of breath, 4th day you
12:46:35 15 responded."
12:46:39 16 There is nothing here, it
12:46:40 17 appears, as to what Ms. Wettlaufer's response
12:46:43 18 was?
12:46:44 19 A. No, it doesn't appear that
12:46:45 20 there was a response.
12:46:49 21 Q. "No follow-up on doctor's
12:46:52 22 orders, come in on time, take
12:46:54 23 full break."
12:46:55 24 Do you know who was referring to
12:46:57 25 that?
12:46:57 26 A. I believe that is Helen
12:46:59 27 telling her that there is no follow-up on
12:47:01 28 doctor's orders, that you have to come in on
12:47:06 29 time and take -- you can take your full break
12:47:09 30 but your break should be half or 15 minutes two
12:47:13 31 times.
12:47:13 32 Q. And what was Ms.

12:47:15 1 Wettlaufer -- do you recall what Ms. Wettlaufer
12:47:16 2 was doing with her breaks?
12:47:17 3 A. I think she -- I believe that
12:47:20 4 she was taking her break all at one time.
12:47:24 5 Q. Okay. It says:
12:47:28 6 "Not acceptable for residents to
12:47:29 7 wait."
12:47:31 8 Do you know who would have made
12:47:34 9 that comment?
12:47:35 10 A. Helen.
12:47:39 11 "Working with Shelly, you
12:47:40 12 said yourself you can work
12:47:41 13 better with supervision and with
12:47:42 14 accountability."
12:47:45 15 Would that have been Helen or
12:47:47 16 Ms. Wettlaufer?
12:47:48 17 A. I think Helen said that to
12:47:52 18 Bethe.
12:47:53 19 Q. Okay. And then on the next
12:47:55 20 page it says:
12:47:56 21 "I will take break separated."
12:48:01 22 Did Ms. Wettlaufer agree to take
12:48:04 23 her break separated?
12:48:05 24 A. Yes, I believe Bethe said
12:48:07 25 that.
12:48:07 26 Q. And then it talks about a
12:48:13 27 post-fall investigation, and the answer:
12:48:16 28 "Ask me to come back in. HC - I
12:48:21 29 shouldn't have to ask you, you
12:48:23 30 are FT RN. When a resident has
12:48:26 31 a serious fall and you do not
12:48:28 32 move until you know their hip is

12:48:31 1 fine or call 911."
12:48:33 2 Is that referring to moving that
12:48:35 3 first resident we talked about that there was a
12:48:37 4 suspected broken hip?
12:48:38 5 A. It is, yes.
12:48:39 6 Q. And I won't read the rest,
12:48:43 7 but it does appear that you met with Ms.
12:48:46 8 Wettlaufer; you discussed these issues; and
12:48:48 9 that resulted in the verbal warning on January
12:48:52 10 16th, is that correct?
12:48:55 11 A. I believe so, yes.
12:48:57 12 Q. Now, there's a number of
12:48:59 13 different situations that -- sorry, I
12:49:03 14 apologize, it wasn't a verbal warning. It was
12:49:06 15 a written warning.
12:49:08 16 There was a number of situations
12:49:09 17 occurring at this point in time, a number of
12:49:12 18 different issues. Why just a written warning?
12:49:14 19 Could you not have given her steeper
12:49:18 20 discipline?
12:49:19 21 A. I guess you can always do
12:49:26 22 that, make that choice to do that, but then if
12:49:33 23 it is fought by the union and it is pushed
12:49:35 24 back, it is -- after a written warning, the
12:49:39 25 next thing would have been a suspension. A
12:49:43 26 suspension is costly, and especially if it has
12:49:46 27 to be retracted and pushed back like then to a
12:49:49 28 written by the union and then it is almost like
12:49:53 29 you are not progressing ahead.
12:49:56 30 So we went with a written.
12:50:00 31 Q. All right. So as I
12:50:01 32 understand that testimony, if you had skipped a

12:50:03 1 step and it was fought and the union was
12:50:08 2 successful, you would have to go backwards to
12:50:10 3 potentially the written warning; is that
12:50:11 4 correct?
12:50:11 5 A. Yes.
12:50:12 6 Q. Okay.
12:50:12 7 A. And then that pay for the
12:50:15 8 suspension, she still would be paid for that
12:50:18 9 day then. We would have to, you know -- I
12:50:22 10 don't know how the wording is with the union
12:50:23 11 but it is something about make them whole
12:50:26 12 again, so --
12:50:28 13 Q. And that would come out of
12:50:29 14 your nursing envelope?
12:50:33 15 A. Yes.
12:50:35 16 MS. HEWITT: Commissioner, I
12:50:36 17 believe this is an appropriate
12:50:37 18 spot for a break. Is that all
12:50:38 19 right for you?
12:50:39 20 THE COMMISSIONER: For the lunch
12:50:40 21 recess, counsel?
12:50:41 22 MS. HEWITT: Yes.
12:50:41 23 THE COMMISSIONER: That is fine,
12:50:42 24 so we would come back at 10 to
12:50:46 25 2:00. Is that acceptable to
12:50:47 26 everyone?
12:50:48 27 Thank you.
12:50:49 28 -- RECESSED AT 12:50 P.M.
13:51:57 29 -- RESUMED AT 1:50 P.M.
13:51:57 30 BY MS. HEWITT:
13:52:08 31 Q. Thank you, Commissioner.
13:52:09 32 Good afternoon again, Brenda.

13:52:13 1 We have been going through quite a few of the
13:52:16 2 disciplinary situations, and I do recognize
13:52:19 3 that a lot of these are nursing-related and you
13:52:22 4 don't have any further information really to
13:52:25 5 tell us.
13:52:25 6 So there's two that I am going
13:52:27 7 to just simply refer the Commissioner to, and I
13:52:30 8 won't refer to the documents.
13:52:32 9 The first is at paragraph 90 of
13:52:36 10 your affidavit, and that related to an incident
13:52:43 11 or an issue where Elizabeth Wettlaufer was not
13:52:48 12 completing admission work for a new resident,
13:52:52 13 and you indicated that she had worked -- she
13:52:56 14 indicated that she had worked seven shifts in a
13:53:00 15 row and that that is actually correct at the
13:53:02 16 time.
13:53:02 17 Did that happen often in terms
13:53:06 18 of nurses having to work a number of shifts in
13:53:09 19 a row?
13:53:09 20 A. I would say it happened a
13:53:12 21 fair enough amount of times.
13:53:14 22 Q. And you identify in that
13:53:16 23 particular situation, if I can go back to my
13:53:21 24 chronology, and this is April 20th of 2012,
13:53:29 25 that you gave her counselling:
13:53:35 26 "We didn't think that this was a
13:53:37 27 strong issue to go any further."
13:53:39 28 Sorry, you gave her a verbal
13:53:39 29 warning.
13:53:42 30 "We know how busy the nurses
13:53:43 31 are."
13:53:44 32 So did that impact your decision

13:53:45 1 at times in terms of discipline?
13:53:47 2 A. I think we looked at the
13:53:51 3 issues and what they were, and yes, as far as
13:54:00 4 doing, you know, some care planning work, that
13:54:06 5 type of thing, we would be more lenient because
13:54:12 6 we knew, you know, the residents were their
13:54:14 7 focus and the book work, the paperwork was, you
13:54:20 8 know, yes, a part of their job, but, you know,
13:54:23 9 the care given was a priority.
13:54:25 10 Q. Okay, thank you.
13:54:27 11 And in June of 2012 there are
13:54:33 12 notes of a meeting with Elizabeth Wettlaufer
13:54:40 13 June 2nd, and this is in paragraph 92 of your
13:54:42 14 affidavit and it indicates that there are a
13:54:45 15 number of different issues happening with her,
13:54:47 16 including she would wait to see if a resident
13:54:53 17 rung again before responding, inappropriate
13:54:55 18 comments about money, bringing in food for
13:54:58 19 staff, sexual orientation and an altercation
13:55:03 20 with a resident.
13:55:04 21 There does not appear to be any
13:55:06 22 discipline on file for this. Do you know or
13:55:11 23 have any independent recollection if in
13:55:14 24 relation to the issues that arose in June 2012,
13:55:18 25 which are found at tab U of your affidavit,
13:55:22 26 whether there would have been any discipline
13:55:26 27 given?
13:55:42 28 Well, there does appear to be an
13:55:45 29 investigative meeting with Bethe. Kathleen
13:55:48 30 Toon, who was Kathleen?
13:55:50 31 A. Kathleen Toon was an RN and
13:55:53 32 she came in as her union rep. If there is no

13:56:04 discipline on the file, I would say that there
13:56:14 wasn't one.
13:56:14 Q. All right, thank you. Now,
13:56:15 that brings us to August 28th to September 4th,
13:56:20 2002, and this is paragraph 94 in your
13:56:24 affidavit. And it indicates in that paragraph
13:56:28 that:
13:56:31 "In August 2012, a concern was
13:56:33 brought to our attention
13:56:34 regarding Elizabeth Wettlaufer
13:56:35 not having assessed a resident
13:56:38 when it was reported that the
13:56:39 resident was not herself."
13:56:41 Now, I'll get Helen Crombez to
13:56:43 deal with the issue as to not having assessed
13:56:51 the resident, but I do want to take you to the
13:56:54 notes of that particular investigation meeting
13:56:56 and that is found at tab number V,
13:57:01 Commissioner, the last document in that tab,
13:57:09 16826, if we can turn to that document.
13:57:13 Now, the top is related to what
13:57:34 the actual resident issue was, so if we can go
13:57:37 down to "took keys home"; do you see that? It
13:57:43 says in this note -- first of all, do you know
13:57:47 whose handwriting this is?
13:57:49 A. It is my handwriting.
13:57:50 Q. And so would you, as you have
13:57:53 indicated before, be taking the notes while
13:57:55 Mrs. Crombez is talking?
13:57:58 A. Yes.
13:57:58 Q. It says:
13:58:00 "Took keys home.

13:58:01 1 OCD and bipolar - changing
13:58:05 2 meds."
13:58:08 3 Do you know who was indicating
13:58:10 4 OCD and bipolar, changing meds?
13:58:16 5 A. I believe Bethe told us she
13:58:18 6 was OCD and bipolar.
13:58:19 7 Q. Prior to this particular
13:58:22 8 investigative meeting, which is in August of
13:58:24 9 2012, had she ever brought any of these issues
13:58:29 10 to your attention?
13:58:30 11 A. Not to my recollection.
13:58:32 12 Q. And in this particular
13:58:38 13 meeting, did she explain why she was talking
13:58:39 14 about being OCD and bipolar and that at that
13:58:44 15 point in time her meds were being changed?
13:58:47 16 A. No, she didn't explain.
13:58:49 17 Q. To the best of your
13:58:52 18 recollection, after this meeting did she raise
13:58:55 19 the issue of any mental health issues such as
13:58:58 20 this again?
13:58:59 21 A. Not to my knowledge, not to
13:59:02 22 my recollection.
13:59:03 23 Q. Did she ever ask for any
13:59:05 24 accommodation for these types of issues?
13:59:08 25 A. Not that I remember, but I
13:59:14 26 don't know if there is more documentation about
13:59:16 27 being put off once for something in a doctor's
13:59:21 28 note.
13:59:21 29 Q. So she may have had a leave
13:59:24 30 of absence, is that what you are saying?
13:59:26 31 A. Yeah, that is what I am
13:59:27 32 thinking.

13:59:27 1 Q. There are a couple of
13:59:29 2 doctors' notes in the file, and they are in the
13:59:31 3 Overview Report, I believe, Commissioner, but
13:59:33 4 they don't identify anything on the specific
13:59:35 5 notes.
13:59:36 6 Now, if I go to the discipline
13:59:42 7 that you handed out, and that is the second
13:59:45 8 document in this particular exhibit, document
13:59:51 9 number 16823, and this identifies that on
14:00:07 10 August 31, 2012, there was discipline given.
14:00:14 11 And again, that is Kathleen Toon's signature at
14:00:19 12 the bottom?
14:00:19 13 A. Yes, it is.
14:00:20 14 Q. And it identifies the
14:00:23 15 incident was:
14:00:23 16 "Not assessing a resident as
14:00:25 17 required when it was reported a
14:00:28 18 resident was apparently not
14:00:29 19 herself.
14:00:39 20 Recommended Disciplinary:
14:00:39 21 Written warning with notice that
14:00:41 22 continued poor performance will
14:00:42 23 result in disciplinary action up
14:00:43 24 to and including termination.
14:00:45 25 If continued poor work
14:00:46 26 performance related to health
14:00:47 27 issues continue, consideration
14:00:49 28 may be given to report to the
14:00:54 29 College of Nurses for 'fitness
14:00:56 30 to practice for review'. Your
14:01:00 31 health and well being is at our
14:01:03 32 utmost concern. Please follow

14:01:06 1 up with the medical issues you
14:01:08 2 discussed with us."
14:01:09 3 And on the bottom left-hand
14:01:13 4 corner of this document, there are handwritten
14:01:16 5 notes again. Whose handwriting that?
14:01:19 6 A. That is my handwriting.
14:01:20 7 Q. All right, and what do you
14:01:22 8 say in that particular "Results of Employee
14:01:26 9 Interview"?
14:01:28 10 "Explained to Bethe that she
14:01:31 11 brought her health issues to us
14:01:32 12 and we are obligated to ensure
14:01:34 13 the safety of the residents."
14:01:36 14 Q. Now, to the best of your
14:01:38 15 recollection, was there any follow-up after
14:01:41 16 this meeting in respect of those health
14:01:44 17 concerns?
14:01:44 18 A. No, I do not believe that
14:01:47 19 there was.
14:01:48 20 Q. And your recollection, I
14:01:49 21 think you said a moment ago, was she never
14:01:51 22 raised those issues with you again?
14:01:55 23 A. No, I don't believe that she
14:01:57 24 did.
14:01:57 25 Q. And was there ever a report
14:02:02 26 given to the College of Nurses other than the
14:02:05 27 one upon her termination in respect of her
14:02:09 28 fitness to practice for review?
14:02:11 29 A. No.
14:02:11 30 Q. Thank you. Now, there were
14:02:24 31 also, within this period, or within this
14:02:28 32 section of your affidavit, some incidents for

14:02:41 1 which there was no discipline, so I would like
14:02:42 2 to go through that with you.
14:02:44 3 One is in relation to again an
14:02:47 4 interaction that Ms. Wettlaufer had with a
14:02:51 5 resident. And so could I take, Commissioner,
14:03:02 6 you to tab number W in this particular Exhibit
14:03:12 7 No. 10 and document 16810.
14:03:15 8 And this appears to be a
14:03:33 9 handwritten note of April 1st, 2013, from Wendy
14:03:38 10 MacKnott, who I understood you to advise
14:03:41 11 earlier is a PSW with Caressant Care?
14:03:44 12 A. Yes, correct.
14:03:45 13 Q. And she states, and again
14:03:48 14 we'll have to be very careful about not naming
14:03:50 15 the residents, just to get it in both of our
14:03:53 16 minds at this point:
14:03:55 17 "Yesterday while at report at
14:03:57 18 7:00 a.m. Beth RN on nights was
14:04:00 19 talking about [a resident] being
14:04:03 20 as she put it (ignorant) to
14:04:06 21 [another resident]. She stated
14:04:08 22 he was making fun of her laugh
14:04:09 23 and she asked him to stop that
14:04:12 24 it was ignorant what he was
14:04:14 25 doing and stated she asked him
14:04:16 26 if he needed a psychiatric
14:04:18 27 assessment done. I feel this is
14:04:21 28 an inappropriate way to talk to
14:04:23 29 residents. If you have any
14:04:24 30 questions please call me."
14:04:27 31 So what is your understanding of
14:04:32 32 what Wendy is trying to say to you when this

14:04:35 1 particular situation happened?
14:04:36 2 A. I think she is telling
14:04:39 3 Mrs. Crombez of what Bethe had said at report
14:04:45 4 in regards to this resident making fun of
14:04:50 5 another resident.
14:04:50 6 Q. Okay. And then while this
14:04:53 7 resident was making fun of another resident,
14:04:57 8 Bethe Wettlaufer allegedly made this comment
14:05:00 9 that what he was doing was ignorant and she
14:05:03 10 asked him if he needed a psychiatric
14:05:05 11 assessment?
14:05:05 12 A. Yes.
14:05:06 13 Q. Okay. And then if I can turn
14:05:09 14 you to document number 16811.
14:05:22 15 A. Yes.
14:05:23 16 Q. This is a letter that is
14:05:30 17 dated "Dear Management" from Laura Long, an
14:05:30 18 RPN --
14:05:37 19 A. Yes.
14:05:37 20 Q. -- at Caressant Care. It
14:05:38 21 states:
14:05:39 22 "On Monday April 1/13 writer
14:05:42 23 heard [Resident] laughing
14:05:44 24 loudly, some mumbled talk, then
14:05:47 25 Beth W saying very loudly to
14:05:49 26 [another resident] do you need a
14:05:53 27 haldol injection? Do you a
14:05:56 28 psychiatric evaluation? She
14:05:57 29 said this 2 or 3 times. I did
14:06:00 30 not see anything, I only heard
14:06:02 31 mumble. I was at the east desk
14:06:04 32 starting med pass because staff

had already gotten up the first few rooms, and were working on my residents this was around 0630. I usually [...]"

That should have been redacted. Sorry, Commissioner, there is a name there that should have been redacted.

THE COMMISSIONER: So can I just clarify? So that name will be redacted before this goes up on the website?

BY MS. HEWITT:

Q. Thank you.

"This is not the first time she has said this. A few weeks ago she did not know I was in the med room, and I only heard her ask if [the Resident] needed haldol. She told me that she asked him if he needed haldol because he was mocking [another resident]. I totally understand what [the first resident]," in terms of the one she asked if she needed haldol, "is going through, it is irritating to a lot of residents. It is difficult in the daytime to talk on the phone. I can see with him having a UTI [...]"

And what is a UTI, Brenda?

A. I don't know the nursing term

for it.

Q. I think it is a urinary tract infection?

A. Yes, it is, thank you.

Q. We can get that confirmed by Mrs. Crombez tomorrow:

"[...] things escalating. Beth and him have had many arguments in the past, and this is the latest of how she's been dealing with it. I do not intervene or say anything for this is Beth and she is the RN. The next time I will ask can I help, and see what I can do to smooth things over, and I promise to report, if my help is not welcomed. Before report in the dining room before it started she said something along the line of him being an ignorant old man, and I asked him if he needed a psyc consult. This is not the exact wording. She stated he was bully. I remember thinking that this isn't everything I heard but anyways. As far as working afternoon shift with her. It not that I can say she doesn't manage her time, she does nothing but meds."

I must indicate, Commissioner, that Ms. Long will have an affidavit posted in this Inquiry as well.

THE COMMISSIONER: Thank you.

BY MS. HEWITT:

"She was on second floor for an unknown amount of time. (I do remember staff asking me when I came back from break where's Beth?) visiting with [another Resident's] daughter. She dilly dally's round sitting with residents, talking to people/staff etc., taking forever to do meds. There is so much more work that can be done. You can talk to residents as you do there meds. Staff don't have time to socialize. I don't even know where to start on this subject.

When I came in one morning she said there was no straws and nothing in storage. I told her yes there is and made her walk over and get them, for I had put them away recently with maintenance. Or one time she said oh, Suzies on nights tomorrow she will restock. She has said this to PSW's along with other things and I have

14:09:36 1 asked them to write it up and
14:09:38 2 they say whats the sense she's
14:09:42 3 still here, nothing ever
14:09:44 4 happens.
14:09:45 5 I swear on my Uncles grave this
14:09:48 6 statement is true. I cannot
14:09:49 7 believe she down and out right
14:09:51 8 lied. She could have at least
14:09:53 9 said yes things got heated, I
14:09:55 10 lost control, what is my
14:09:56 11 punishment. I am not a perfect
14:09:58 12 person but will always admit my
14:10:00 13 mistakes, because we all have
14:10:02 14 those days."
14:10:04 15 Now, I don't believe in respect
14:10:15 16 of these two exhibits that there was any
14:10:25 17 reference to a meeting with Elizabeth to
14:10:29 18 discuss this or any reference to discipline.
14:10:32 19 Do you recall these two letters at all and what
14:10:36 20 would have happened around that time?
14:10:37 21 A. I don't recall the letter
14:10:41 22 from Laura Long, and the previous one from
14:10:50 23 Wendy I didn't recall it until I was, you know,
14:10:54 24 shown it in my interview.
14:10:56 25 I do believe that Bethe was
14:11:00 26 spoken to by Mrs. Crombez, so you will have to
14:11:04 27 ask her.
14:11:04 28 Q. Okay, I will do that. There
14:11:06 29 was an incident with this particular resident
14:11:09 30 at the same time involving he and Elizabeth
14:11:15 31 Wettlaufer.
14:11:17 32 Just before I get to that, was

14:11:20 this particular -- no, I'm going to leave that
14:11:30 question for now.
14:11:30 Let's go to the next document,
14:11:32 which is a Critical Incident Report that you
14:11:35 filed on April the 1st, 2013. It is document
14:11:42 00639. Now, my understanding, Brenda, is that
14:11:59 this Critical Incident Report on April the 1st,
14:12:03 2013, involves the same resident to which these
14:12:07 two individuals were indicating Beth made a
14:12:10 comment along the lines of, you know, do you
14:12:13 need haldol, do you need a psychiatric
14:12:16 evaluation. Is that --
14:12:18 A. I believe that is correct.
14:12:18 Q. So on the same day, this
14:12:21 particular resident -- and I should say, do you
14:12:26 know, although these are dated April 1st, 2013,
14:12:29 do you have any idea when you would have
14:12:31 actually received those two letters?
14:12:34 A. The two prior letters?
14:12:37 Q. Yeah, the two prior letters.
14:12:39 There is nothing on --
14:12:41 A. Received April 3rd, the one
14:12:51 letter from Laura long was received April 3rd.
14:12:57 Just I have to check back.
14:12:59 Q. And you are referring -- yes,
14:13:02 you are right -- to the bottom right-hand
14:13:04 corner of that document says "received April
14:13:07 3rd, 2013."
14:13:09 A. Yes, and the other document
14:13:10 from Wendy MacKnott was dated April 1st but it
14:13:17 does not say when it was received.
14:13:19 Q. Okay. So one is at least

after the particular -- was received after the incident report, and the other one you are not sure of?

A. No, I'm not sure.

Q. So in this particular incident report then, it indicates:

"Resident came to my office this morning to say he did not want Bethe Wettlaufer giving him medication again as he did not trust her to give him his correct medication. He said if she comes near me again he would kick her and punch her in the teeth. Resident said he 'would kill her', 'kick the shit out of her'," pardon my language, Commissioner, "'kick her until her bowels are on the floor', 'I'll kill her and go to another nut house. I'll go to jail.' Bethe Wettlaufer charted the following."

And by that, would that mean what she put on the resident's chart?

A. That was what she had charted that day, yes, about the incident.

Q. Okay. So:

"[This Resident] came out of his room at 05:45 and sat near resident room 2 bed 4. Whenever that resident laughed, [this

14:14:28 one] would voice a fake laugh
14:14:30 and then say 'look at me, I'm a
14:14:33 laughing fool too'.
14:14:35 Intervention. [Resident] was
14:14:38 informed by writer that his
14:14:40 actions were rude and bullying
14:14:43 and he was asked to stop.
14:14:45 [Resident] was also reminded by
14:14:47 writer that resident [...]"
14:14:51 Again, this should be redacted,
14:14:53 Commissioner, so we'll redact this before it is
14:14:55 put on the website.
14:14:57 THE COMMISSIONER: Are you
14:14:57 talking about the words
14:14:59 "resident room 2 bed 4"
14:15:01 identifying?
14:15:02 MS. HEWITT: Yes.
14:15:03 THE COMMISSIONER: Thank you.
14:15:04 BY MS. HEWITT:
14:15:05 "...had agreed that if
14:15:07 [Resident] had told her laughing
14:15:08 bothered him and asked her to
14:15:10 move, that she would move."
14:15:11 So in this particular incident,
14:15:13 Brenda, it looks like Bethe Wettlaufer actually
14:15:17 charted that interaction with the resident?
14:15:20 A. Yes, she did.
14:15:21 "Time and frequency: 1
14:15:23 staff x 5 minutes x 3."
14:15:25 What does that mean?
14:15:26 A. It took one staff times five
14:15:30 minutes to deal with it three times.

14:15:33 "Evaluation: Ineffective.
14:15:36 [Resident] became angry and
14:15:37 threatened writer that he would
14:15:40 kick her stomach through her
14:15:42 spine and smash her teeth in
14:15:44 with his fist."
14:15:45 So you did report both instances
14:15:49 in this case to the Ministry based upon the
14:15:59 charting that Bethe Wettlaufer had actually
14:16:01 made?
14:16:01 A. Yes, and I believe Helen
14:16:03 reported it as the resident came and reported
14:16:06 the concern to her as well.
14:16:10 Q. There is above this section,
14:16:12 it says "Select relevant sub-category as
14:16:15 applies to abuse/neglect: Resident to staff."
14:16:19 So that is actually a resident abusing a staff
14:16:22 member. Is that reportable under the Long-Term
14:16:26 Care Act, do you know?
14:16:27 A. There is -- I don't know
14:16:31 about under the Long-Term Care Act, but in our
14:16:34 policy there can be resident to staff abuse.
14:16:38 Q. All right, and we'll look at
14:16:39 that policy in a moment then. And in respect,
14:16:42 though, of the interaction between Elizabeth
14:16:47 Wettlaufer and this resident when he was
14:16:51 interacting with another resident, why wouldn't
14:16:53 that have been reported or in your view should
14:16:57 it have been reported, the comments that she
14:16:59 made to him?
14:17:01 A. I think you'll have to ask
14:17:05 Helen why she selected the resident to staff.

14:17:08 1 It could have went under resident to resident
14:17:12 2 abuse. It fell under maybe different
14:17:14 3 categories and she chose that one.
14:17:15 4 Q. And the actual, I think we
14:17:19 5 reviewed the wording earlier today, was "abuse
14:17:23 6 of a resident or neglect of a resident by
14:17:38 7 anyone that resulted in harm or the risk of
14:17:41 8 harm to the resident." What was your
14:17:46 9 understanding of what that meant, "harm or risk
14:17:48 10 of harm" when it relates to comments being made
14:17:50 11 to a resident?
14:17:51 12 A. It could be, like, emotional
14:17:54 13 abuse.
14:17:56 14 Q. And can you give us an
14:17:58 15 example of your understanding of what emotional
14:18:01 16 abuse, what type of comment, in your view,
14:18:04 17 would rise to the level of having to be
14:18:06 18 reported to the Ministry?
14:18:07 19 A. Well, in referring to this
14:18:12 20 incident, I would say that the resident, it was
14:18:16 21 a male resident mocking a female resident, I
14:18:21 22 would say the female resident could have been
14:18:24 23 emotionally abused.
14:18:27 24 Q. All right. And would you
14:18:30 25 take that same view of the comments that
14:18:33 26 Elizabeth Wettlaufer made to the resident as he
14:18:36 27 was doing this with the other resident?
14:18:38 28 A. I took the comments that --
14:18:44 29 Bethe repeated to the resident what he had said
14:18:47 30 to the other resident, and I took that as an
14:18:51 31 inappropriate nursing measure, but I think she
14:18:54 32 was trying to make him realize how awful he was

14:18:58 sounding because he was saying to that
14:19:02 resident, you are laughing, you know, do you
14:19:04 need medication, blah, blah, blah, and I think
14:19:10 Bethe's nursing measure, although
14:19:12 inappropriate, was just to make him realize and
14:19:16 stop saying what he was saying.
14:19:17 Q. And in this particular
14:19:20 instance there does not appear to be any
14:19:24 reference to a discipline for Elizabeth
14:19:29 Wettlaufer?
14:19:29 A. No. I do believe that the
14:19:32 Director of Nursing spoke with her.
14:19:33 Q. Okay. And then if we can
14:19:38 just finish up this particular Critical
14:19:46 Incident Report. On page number 2 under
14:19:54 "Actions taken":
14:19:57 "Resident came and spoke with me
14:19:59 and I informed Administrator who
14:20:02 spoke to resident in his room.
14:20:04 Resident was still very angry
14:20:06 when speaking about Bethe and
14:20:08 kicked his dresser with force to
14:20:10 demonstrate how he would kick
14:20:11 Bethe."
14:20:12 And then over to the third page,
14:20:22 it appears that the police were called in
14:20:25 respect of these particular comments, and it
14:20:27 indicates that the officer said to the resident
14:20:34 that the resident was calm now and the resident
14:20:39 had assured him there would be no further
14:20:41 incident.
14:20:43 Under "Analysis and follow-up"

it states:

"I spoke to [the Resident] and asked if she would mind changing her morning routine."

My understanding is that Mrs. Crombez is referring to the resident that was spoken to by --

A. Yes, the male -- she is referring to the female resident who does the hysterical laughter.

Q. Okay.

"I asked her if she would mind sitting in the family room and watch the early morning news until about 07:30 when she could make her way to the dining room if she wanted. [That Resident] had no problem with this and agreed to it right away. She said she would start tomorrow. B. Wettlaufer advised with a voice message last evening April 1/13 to not approach resident alone at any time. She is to have a PSW with her at all times when entering his room or dealing 1:1 with resident. Urine dip test to be done for [Resident] to rule out urine infection. Urine dip test indicated urine infection. Dr. George notified April 2/13

14:22:03 1 of resident's behaviour and
14:22:05 2 results of urine dip test.
14:22:07 3 Urine sample sent for C&S and
14:22:09 4 order received for Septra.
14:22:13 5 Resident accepted his blood
14:22:15 6 sugar tested this morning from
14:22:17 7 Bethe and she had a PSW go into
14:22:19 8 resident's room with her."
14:22:25 9 Were there any further issues,
14:22:29 10 to the best of your recollection, with respect
14:22:31 11 to this resident and Ms. Wettlaufer?
14:22:34 12 A. Not that I can recall.
14:22:40 13 Q. The other document, incident,
14:22:48 14 that appears to have been brought to
14:22:50 15 management's attention is June 7th, 2013. It
14:22:56 16 is document number 16796, and it is found,
14:23:09 17 Commissioner, at Exhibit Y. This is a letter
14:23:19 18 dated June 7th, 2013, from Brenda Black. You
14:23:24 19 will hear from Brenda Black during the course
14:23:28 20 of these proceedings, Commissioner.
14:23:29 21 Ms. Black writes -- let me ask
14:23:35 22 you first, are you aware of what Ms. Black's
14:23:37 23 position is at Caressant Care?
14:23:39 24 A. She is a PSW.
14:23:41 25 Q. She is another PSW, thank
14:23:43 26 you.
14:23:45 27 "Last week (midweek) I'm not
14:23:47 28 sure of the exact day I
14:23:49 29 witnessed the nurse BW," who we
14:23:52 30 believe to be Elizabeth
14:23:54 31 Wettlaufer, "do something which
14:23:55 32 was highly unprofessional and

14:23:57 1 very inappropriate. Between
14:23:58 2 7:30 a.m. and 8:00 a.m. I was
14:24:01 3 pushing a resident into the
14:24:02 4 dining room. We were standing
14:24:03 5 right in front of the dining
14:24:06 6 room doors and Beth said to me,
14:24:09 7 oh, wait she loves it when I do
14:24:12 8 this. Then Beth turned so her
14:24:15 9 backside was facing the resident
14:24:17 10 and myself and proceeded to
14:24:19 11 shake her butt in the resident's
14:24:23 12 face. The resident wasn't
14:24:25 13 paying attention at first but
14:24:27 14 Beth made it a point to call her
14:24:29 15 name multiple times so she had
14:24:31 16 her full attention. Then Beth
14:24:33 17 carried on and went back to
14:24:38 18 work."
14:24:38 19 Now, there did not appear to be
14:24:43 20 any notes of discipline with respect to this
14:24:47 21 particular incident, so how did you view --
14:24:52 22 number one, was this brought to your attention
14:24:54 23 at the time?
14:24:54 24 A. Yes, it was brought to my
14:24:55 25 attention.
14:24:56 26 Q. And how did you view this
14:24:57 27 particular situation?
14:24:58 28 A. Well, again, with the notes,
14:25:04 29 a PSW is reporting something that happened over
14:25:06 30 a week ago. I really felt and still do feel
14:25:13 31 that if something is that important that you
14:25:17 32 thought it was so wrong, you would bring it to

14:25:20 1 our attention right away.
14:25:22 2 And I did speak with Bethe on
14:25:25 3 this, and Bethe joked around with this
14:25:27 4 resident. She liked to make the resident
14:25:30 5 laugh, and she did wiggle her butt in front of
14:25:34 6 the resident and the resident, you know --
14:25:38 7 there was no harm, it was just all in fun.
14:25:40 8 Q. And hence no --
14:25:44 9 A. No discipline. But I did
14:25:45 10 speak to her and say that it wasn't
14:25:48 11 appropriate, but I didn't put anything on her
14:25:50 12 file.
14:25:50 13 Q. Thank you. On November 8th,
14:26:00 14 2013, the evidence indicates that you received
14:26:04 15 a letter from another staff member. This staff
14:26:14 16 member was Dianne Fleming?
14:26:18 17 A. Yes, it was.
14:26:18 18 Q. My understanding is that Ms.
14:26:21 19 Fleming is deceased; is that correct?
14:26:23 20 A. Yes, she is. She was a PSW.
14:26:26 21 Q. A PSW. If I can turn you to
14:26:28 22 document 16793 which is found at tab Z,
14:26:37 23 Commissioner.
14:26:38 24 This document states:
14:26:53 25 "Beth Wettlaw," and we believe
14:26:57 26 it is Elizabeth Wettlaufer, "is
14:27:00 27 a bully, she thinks she is in
14:27:02 28 charge of our every movement,
14:27:03 29 she will interrupt us in our
14:27:05 30 work, to tell us to do something
14:27:07 31 she wants. In the dining room
14:27:08 32 she tells us when we can start

14:27:09 1 serving, what we should be
14:27:11 2 doing."
14:27:12 3 Now, if I just stop there, does
14:27:14 4 the RN have supervision over the dining room?
14:27:17 5 A. Yes, yes, they do.
14:27:27 6 "She tells us to toilet
14:27:29 7 people during dinner. She told
14:27:30 8 me if I wanted to help serve
14:27:32 9 dessert to wear a hair net
14:27:34 10 because then I become part of
14:27:36 11 the kitchen help."
14:27:38 12 Is that a requirement in the
14:27:39 13 home, that if somebody is serving, they wear a
14:27:41 14 hair net?
14:27:41 15 A. It depends on if they are in
14:27:44 16 the servery serving or if they are just taking
14:27:50 17 the plate from the counter to the table.
14:27:51 18 Q. All right. So as I
14:27:52 19 understand that, if you are actually dishing up
14:27:58 20 the dinner, you should be wearing a hair net?
14:28:01 21 A. You should be wearing a hair
14:28:03 22 net.
14:28:03 23 Q. Thank you.
14:28:04 24 "She spoke very loud to me in a
14:28:08 25 you do as I tell you voice. I
14:28:10 26 told her not to speak to me like
14:28:11 27 that. She later apologized
14:28:13 28 saying quote 'I am controlling,
14:28:16 29 I do use my authority'. This
14:28:19 30 happens often in the dining room
14:28:20 31 in front of residents and
14:28:21 32 family.

October 6, 2013 [...]"
So it looks like at the top of this document it is dated, it appears, October something, 2013, and it is crossed out and says November 8th, 2013? You have to say yes or no; sorry.
A. Yes.
"October 6, 2013 I was sitting in the chair across from the desk, Beth was at the desk sitting, Vannessa had just finished her charting also sitting behind the desk."
And these are staff members, I believe?
A. Yes, they are.
Q. Thank you, and there is one line cut off, it appears. We'll go to the top of the next document:
"She was calling a family member at 10:40 in the evening. I didn't know," and I believe this to be referring to Elizabeth Wettlaufer, Commissioner, "I didn't know she was on the phone, I couldn't see her. I asked her why she sh sh us. She said she was on the phone. I asked her what the sh sh was for. She told me we were talking too loud. I asked her not to sh me again. I was not a

child, she could ask me to lower my voice. She stood up behind the desk and told me I was being insubordinate and she was my supervisor and I had to obey her. Then she accused me of not wanting to toilet [a Resident] at 3:15 that she heard me and wrote it down at the time, and that she asked to put a housecoat on [another Resident] and that I refused to toilet November 6, 201663, and that she knows 3 people that won't work over here because of me. And that she was going to report me. I told her to go ahead.
Beth also makes comments to me, example: How do you feel working here when there are residents younger than you. When are you going to retire. She handed me a ruler that was in [...]"
A. That was in inches.
"[...] in inches. She says 'is this yours'. I say 'no'. She laughs and says 'it's from your generation.' I feel she singles me out. I don't know why she told her mother how I had her back. She also said

'this wing is so much better with me here. 'This is Agatha and mine wing.' Beth is a controller. She should not be in a position where she thinks she can get away with it. PSWs are not comfortable when she works. I tried to ignore her remarks and her controlling ways but she has an agenda, she wants to control me and now she threatens to report me. Both Mary and Vanessa said she is way out of control and she is a bully and uses her authority to do this. There is more which I will be happy to discuss in person. I can't write out everything. These are most recent."

Now, do you recall what you did with respect to this particular letter after it was received?

A. I believe I stated in my affidavit that I did recall talking to Dianne Fleming in my office with another person. I don't know if that other person was Bethe or if the other person was a union rep. I do know that I felt that the first part of the letter where Bethe was telling her to be quiet while she was on the phone, about wearing the hair net, Bethe was doing her duties as a nurse and

14:32:38 the PSW was not happy with that.
14:32:41 But I also gave Dianne a form
14:32:49 because we had a harassment policy in the
14:32:52 workplace, and the first part on the harassment
14:32:58 policy states that, you know, if you have a
14:32:59 bully, you are supposed to tell the bully to
14:33:02 stop, you are supposed to tell them yourself;
14:33:05 and if they don't stop, then you are supposed
14:33:08 to report it; and then they can report it on a
14:33:11 form to me. And I gave her that form and
14:33:12 policy because I felt what she was saying about
14:33:18 the age comments were inappropriate and I gave
14:33:26 -- I told Dianne she could fill that out.
14:33:29 Q. And, Commissioner, it appears
14:33:31 that when the document was printed with the
14:33:34 benefit of the number on the bottom right-hand
14:33:37 side, it obscured some of the handwriting. Is
14:33:41 that your handwriting on the bottom right-hand
14:33:43 side?
14:33:44 A. Yes.
14:33:44 Q. And correct me if I'm wrong,
14:33:47 but if you take out the document ID, it
14:33:50 identifies "gave harassment form" or "to give
14:33:55 harassment form"?
14:33:56 A. Yes, something about the
14:33:57 harassment form, "gave her a harassment form."
14:34:01 Q. Did you ever get a formal
14:34:03 complaint?
14:34:03 A. Not to my recollection. If I
14:34:05 would have, I -- I can't even say if my memory
14:34:10 would recall that, but I don't believe that I
14:34:14 did.

14:34:14 Q. Is it your understanding that
14:34:18 unless an employee filled out a formal written
14:34:23 complaint, that there was no obligation to
14:34:27 investigate something when it is actually in
14:34:30 letter form?
14:34:30 A. I think, because of the
14:34:36 length of this and the time period it covered,
14:34:39 I felt that Dianne was reporting things that
14:34:47 had happened in the past and I was just -- you
14:34:51 know, we were inundated with letters from
14:34:54 staff. When Bill 168 came out, and, you know,
14:34:57 harassment was added, everyone was a bully to
14:35:00 them, and you know what, we just started
14:35:02 saying, okay, we need to do proper reporting.
14:35:05 Q. And give them the --
14:35:09 A. Yes.
14:35:11 THE COMMISSIONER: Thank you. I
14:35:12 didn't understand that, give
14:35:13 them what?
14:35:14 BY MS. HEWITT:
14:35:15 Q. Give them the complaint form?
14:35:16 A. Give them the complaint form
14:35:18 to fill out for bullying.
14:35:20 Q. Now, you say in your
14:35:22 affidavit at paragraph 110 that in addition --
14:35:36 maybe we'll just bring this portion up,
14:35:38 Commissioner. If we can go to the affidavit
14:35:41 again, and this is document number AFF1.
14:36:01 And if we can go to paragraph
14:36:28 number 110, which I believe would be page 24,
14:36:39 and it starts off:
14:36:41 "In addition to dealing with

Elizabeth Wettlaufer's work performance, at this time she was also making more medication errors. By November, 2013 she had already been given a written notice, a 1 day suspension and a 5 day suspension for those errors."

So as I understood your testimony this morning, Brenda, the medication errors would be dealt with separately, in a separate discipline stream?

A. Yes.

Q. And so at that time you were already up to a five-day suspension on the medication error side of things?

A. It appears that way, yes.

Q. And you continue:

"In November, 2013 there was an issue regarding Elizabeth Wettlaufer having been given a urine sample by a resident's wife and not having done a dip test right away. We met with Elizabeth Wettlaufer about this on November 25, 2013. The notes of that meeting indicate that she said that there were no signs of a urinary tract infection and that she did not think that the doctor would do anything. She stated that a PSW

had given her the sample, that there was no paper with it and she forgot it. She indicated that she had found it Thursday and had destroyed it and had apologized at least twice.

By November, 2013, I was corresponding with Wanda Sanginesi, telling her that Elizabeth Wettlaufer was making more and more mistakes and the discipline was not getting through. We did not give Elizabeth Wettlaufer discipline on this occasion. We gave her a letter that said 'Your file indicates that you are up to a five day suspension. We do not want to proceed to further discipline. We want to give you every opportunity to improve. We know you are capable.'"

Can you expand a bit on what in totality was going on with Elizabeth Wettlaufer at this point in time?

A. There was a lot of issues at that time with Elizabeth. She was receiving disciplines. You know, we were pretty busy with disciplines with her, and she was going -- you know, it was leading to termination. And I was conferring with head office, and we wanted to make sure that she had every opportunity to

14:39:41 change.
14:39:43 And Wanda wanted to build a big
14:39:48 file, you know, enough, a strong enough case
14:39:51 that we gave her every opportunity to improve.
14:39:56 So instead of a formal
14:40:00 discipline on the discipline forms that we
14:40:06 normally used, we tried a different tactic in a
14:40:11 letter to make her, you know, and the union
14:40:16 realize that this was serious.
14:40:18 Q. And if I can turn then,
14:40:23 Commissioner, to document 16789, and that is at
14:40:29 tab AA, the last document in that tab. Exhibit
14:40:43 AA, I should say.
14:40:55 So this is a different type of
14:41:23 document than the disciplinary forms that we
14:41:26 have seen before?
14:41:27 A. This letter, yes. I have
14:41:30 just not got that -- oh, it is in front of me,
14:41:33 okay.
14:41:33 Q. It is the last document, it
14:41:35 should be the last document at your tab AA.
14:41:39 A. Yes, okay.
14:41:40 Q. Now, and you may have said
14:41:45 this this morning, Brenda, so I apologize if
14:41:49 I'm asking the question again, but what was
14:41:53 Wanda Sanginesi's position with Caressant Care?
14:41:59 A. I believe it is vice
14:42:01 president of human resources.
14:42:02 Q. And you indicated earlier
14:42:05 that you would have to contact head office if
14:42:07 you were going to suspend or terminate. So at
14:42:11 this point in time, was she your contact?

14:42:13 A. Yes.
14:42:13 Q. Okay. And the letter reads:
14:42:19 "This letter is to inform you
14:42:20 that you are not working to the
14:42:22 best of your ability. A
14:42:24 resident's family complained
14:42:26 that they gave you a urine
14:42:28 sample for their loved one.
14:42:30 This urine sample was put in the
14:42:34 refrigerator and later discarded
14:42:37 as it was stale. The family was
14:42:41 upset and reported the issue to
14:42:43 management. It was your
14:42:45 responsibility as an RN to
14:42:47 ensure this sample was processed
14:42:51 properly. You failed to do
14:42:54 this.
14:42:55 Also your work performance is
14:42:57 not adequate. You are not doing
14:43:02 assessments, processing and
14:43:03 following up on doctor's orders,
14:43:06 or other work as required of the
14:43:09 Registered Staff. There is
14:43:11 daily work that is required to
14:43:13 be done in a timely matter.
14:43:17 This letter is to inform you
14:43:18 that it is expected that you do
14:43:21 the required work in a timely
14:43:23 fashion. The Registered Staff
14:43:27 must work as a team in order to
14:43:28 meet the needs of the resident.
14:43:30 We expect you to do your part.

14:43:35 1 Bethe, you are a good nurse and
14:43:36 2 a valuable member of the nursing
14:43:38 3 department. We hope that you
14:43:40 4 take this counselling seriously.
14:43:42 5 Your file indicates that you are
14:43:46 6 up to a five day suspension. We
14:43:48 7 do not want to proceed to
14:43:50 8 further discipline. We want to
14:43:52 9 give you every opportunity to
14:43:53 10 improve. We know you are
14:43:56 11 capable."
14:43:59 12 So after everything that we have
14:44:01 13 seen and we have gone through this afternoon,
14:44:07 14 why are you identifying "Bethe, you are a good
14:44:11 15 nurse"? Did you think she was a good nurse at
14:44:15 16 that point in time?
14:44:15 17 A. I think that we thought she
14:44:19 18 had the capabilities of being a good nurse and
14:44:21 19 I think we wanted to leave it that it is
14:44:23 20 positive, you know, to support her, but also
14:44:29 21 with pointing out to her everything that wasn't
14:44:32 22 right.
14:44:33 23 Q. Now, this is dated November
14:44:46 24 25th, 2013, and I want to take you now to the
14:44:55 25 medication errors that we have referenced
14:44:58 26 slightly. And in respect of those matters, I
14:45:03 27 want to start at paragraph 115 of your
14:45:12 28 affidavit, which I believe would be on page 25.
14:45:51 29 And so on the medication error side of things,
14:45:55 30 we can see the discipline or counselling that
14:46:01 31 was done with Bethe Wettlaufer between 2011 and
14:46:10 32 2014 as counselling, written notice, one-day

14:46:14 suspension, five-day suspension.
14:46:16 And I want, for the interests of
14:46:19 time, Commissioner, because Brenda does
14:46:23 identify these issues, for the interests of
14:46:25 time I want to start our discussion at the
14:46:28 April 12th five-day suspension.
14:46:37 And in that respect, at
14:46:40 paragraph 123 of your affidavit, and we won't
14:46:48 need to go to the document, you indicate that:
14:46:54 "It was reported that on April
14:46:56 8, 2013 Elizabeth Wettlaufer
14:46:57 signed again for a medication
14:46:58 that she had not given. She was
14:47:00 given a five day suspension."
14:47:05 Now, my understanding from your
14:47:07 affidavit is that ONA grieved that suspension;
14:47:10 is that correct?
14:47:11 A. I believe it was that
14:47:13 suspension, yes.
14:47:14 Q. And it says at paragraph 124
14:47:19 that:
14:47:21 "ONA filed a grievance for this
14:47:26 suspension [...]"
14:47:28 And then it was subsequently
14:47:30 withdrawn. And there is a letter to that
14:47:35 effect -- you don't need to turn to it now,
14:47:37 I'll just point it to your attention,
14:47:39 Commissioner, it is at Exhibit GG, the last
14:47:44 document, document number 72546 indicating:
14:47:51 "Please be advised that the
14:47:53 grievor," Elizabeth Wettlaufer,
14:47:57 "has requested that the union

withdraw the above-referenced grievance."

So at this point in time -- and that is dated, Commissioner, July 30th, 2013, so at this point in time, as I understand it, Brenda, Elizabeth Wettlaufer on your medication side of things is at a five-day suspension, it has been grieved but the grievance no longer exists; correct?

A. Yes.

Q. Now, on December 19th, 2013, another issue arises with Elizabeth Wettlaufer, and this is -- these documents are found at Exhibit HH, and in terms of the issue, I'll just read from your affidavit:

"In December, 2013," this is paragraph 125, "another issue arose in relation to Elizabeth Wettlaufer not waiting in between putting different types of eye drops into a resident's eyes even though she had been told by a family member that that was not the way to do it. Elizabeth Wettlaufer indicated in our meeting on December 19, 2013 that it was an error on her part and it was a very busy night."

What I want to ask you about, Brenda, is your notes from that particular meeting with Elizabeth Wettlaufer, which are

found at document 16780 at Exhibit HH, the second document in that tab, Commissioner, and in the middle of the page it states:

"Helen spoke of nursing med practices. Should be wait time in between."

Is this your handwriting again?

A. This is my handwriting.

Q. All right. And then it states:

"I gave both at once. [The resident'," I think this is the resident's wife that is DC, "has lost faith."

Then it says:

"It is the only time I have done this."

Then it goes on to say:

"Definitely an error on my part. It was a busy night."

But at the third page of this document, if we could scroll down to the top of the third page, it says:

"We are going to put this on your file. Very serious issues. With the Christmas season. If we sent this to HO, the outcome wouldn't be good."

What is HO?

A. Head office.

Q. All right, and who is speaking?

14:51:36 A. Helen was speaking.
14:51:38 Q. So Helen Crombez is saying,
14:51:43 we are going to put it on your file, very
14:51:46 serious issues, it is the Christmas season, if
14:51:50 we sent this to head office, the outcome
14:51:52 wouldn't be good. What was meant by this
14:51:54 conversation?
14:51:55 A. I don't know, because I do
14:52:00 believe that it was discussed with head office,
14:52:05 and Helen was speaking, so you will have to ask
14:52:11 her.
14:52:13 Q. All right. She was up to a
14:52:15 five-day suspension. Did you terminate her?
14:52:18 A. No.
14:52:18 Q. Why not?
14:52:19 A. We gave her another letter.
14:52:22 Q. And if I can -- your
14:52:28 affidavit indicates that:
14:52:31 "We were building the case on
14:52:32 her." And this is at page 126.
14:52:36 "We also did not want to
14:52:37 terminate her just before
14:52:39 Christmas."
14:52:40 Did that have a factor at all,
14:52:42 the timing of this particular error?
14:52:44 A. I would think that it did,
14:52:47 and that the fact that it was serious, I don't
14:52:52 know how serious it is, I am not a nurse, about
14:52:55 giving eye drops to, you know, one right after
14:53:00 another. I think you have to wait five minutes
14:53:02 for them to be effective.
14:53:04 But also, you know, that may be

not the most serious error that she made. You know, it wasn't one of the most serious errors.

Q. And again, I won't take you there, Commissioner, but there is a letter dated 19th, 2013, at Exhibit HH which identifies -- a similar letter to the November 25th, 2013, which identifies a number of things that are wrong and states:

"Bethe, we want to take the above seriously. We cannot continue to have a good working relationship if these issues continue. We hope for improvement in the new year. You are a valuable member to the nursing team."

Now, in terms of the progression then of issues, in 2014, between January 20th and January 28th, as I understand it from the documents and from your affidavit, there was a medication incident involving Maureen Pickering; is that correct?

A. Yes.

Q. All right. Now, in terms of that incident, I'll leave those questions to Mrs. Crombez because they relate to medication, et cetera. But in respect of those incidents, it appears that you wrote another letter providing a five-day suspension?

A. Yes.

Q. And that is found, Commissioner, at Exhibit II, document 16739.

14:55:27 1 And sorry, Commissioner, it is the last
14:55:29 2 document in your tab?
14:55:31 3 THE COMMISSIONER: Thank you.
14:55:40 4 BY MS. HEWITT:
14:55:40 5 "This letter is to inform you
14:55:42 6 that you are not working to the
14:55:43 7 standards required for Caressant
14:55:45 8 Care. A resident was given
14:55:46 9 medication outside of the
14:55:47 10 allowable time frame, this same
14:55:49 11 resident was spoken to in an
14:55:51 12 inappropriate manner that
14:55:52 13 resulted in upsetting the
14:55:54 14 resident and you failed to
14:55:55 15 document the interventions that
14:55:56 16 you said you tried for this
14:55:58 17 resident. All of these issues
14:56:00 18 are being brought to your
14:56:01 19 attention. Please reflect on
14:56:03 20 your actions."
14:56:08 21 And again, Commissioner, I'll
14:56:10 22 canvass this incident with Mrs. Crombez.
14:56:11 23 "You are receiving a five day
14:56:13 24 suspension with warning that
14:56:14 25 continued poor work performance
14:56:17 26 will lead to further discipline
14:56:19 27 up to and including
14:56:20 28 termination."
14:56:23 29 It then provides the suspension
14:56:25 30 dates:
14:56:26 31 "Bethe, we want you to take the
14:56:27 32 above seriously. We cannot

14:56:29 continue to have a working
14:56:31 relationship if these issues
14:56:32 continue. We expect that these
14:56:34 types of issues are addressed
14:56:36 immediately and will not happen
14:56:38 again."
14:56:40 So we have a five-day suspension
14:56:48 in April, a letter in November, a letter in
14:56:53 December, and another five-day suspension in
14:56:57 January. So can you advise as to what, if you
14:57:03 can recall, what were the factors involved at
14:57:07 this time that Bethe Wettlaufer would not have
14:57:11 been terminated after a five-day suspension?
14:57:14 A. I think that you will have to
14:57:16 talk to head office on that one.
14:57:18 Q. All right. So as you
14:57:21 indicated this morning, those permissions for
14:57:24 terminations come through head office?
14:57:25 A. Yes.
14:57:26 Q. Now, your affidavit indicates
14:57:33 that on January 30th, 2014, so the discipline
14:57:44 is January 28th, 2014, and on January 30th ONA
14:57:49 grieved that suspension; is that correct?
14:57:51 A. Yes, I believe they did.
14:57:53 Q. Just for your sake,
14:57:56 Commissioner, I won't take you to it, but that
14:57:59 is at Exhibit JJ, the grievance.
14:58:02 And at the time of her
14:58:04 termination, was that five-day suspension
14:58:09 grievance still in existence, to the best of
14:58:11 your knowledge?
14:58:11 A. I believe that it was.

14:58:13 Q. The next document I'm getting
14:58:18 into, Commissioner, is the circumstances
14:58:20 surrounding Elizabeth Wettlaufer's termination.
14:58:24 Would you like to take the afternoon break now
14:58:27 or get into this? I'm at your --
14:58:32 THE COMMISSIONER: Help me
14:58:32 understand how the balance of
14:58:34 the afternoon is going to play
14:58:35 out, and then we'll sort that
14:58:37 out.
14:58:38 MS. HEWITT: We still have the
14:58:39 issue with respect to this last
14:58:41 medication incident, the
14:58:44 termination of Elizabeth
14:58:46 Wettlaufer, the report to the
14:58:48 College of Nurses, and the
14:58:50 impact of these offences.
14:58:52 So I can't tell how much longer
14:58:55 that I would be, but probably at
14:58:57 least 45 minutes, and then it
14:59:00 would be -- and then after my
14:59:02 submissions, I believe
14:59:04 Mr. Golden has the opportunity
14:59:05 to ask the witness some
14:59:07 questions, and then there was a
14:59:09 list, a protocol of potential --
14:59:13 people that could potentially
14:59:14 cross-examine.
14:59:15 THE COMMISSIONER: Well, if you
14:59:15 are going to be another 45
14:59:17 minutes, then maybe this is a
14:59:18 better time to take the break.

14:59:20 MS. HEWITT: Thank you.
14:59:22 -- RECESSED AT 3:00 P.M.
15:17:12 -- RESUMED AT 3:17 P.M.
15:17:12 BY MS. HEWITT:
15:17:12 Q. Thank you, Commissioner.
15:17:13 Things are always going along
15:17:15 swimmingly, and then you decide I should
15:17:18 actually go and fill in some hole, so I'm going
15:17:21 to go back in time for a moment.
15:17:22 And I am going to go to an issue
15:17:26 that arose in March of 2013. First of all,
15:17:34 Brenda, if I can turn you to, just for your
15:17:38 reference and the Commissioner's, paragraph 121
15:17:41 of your affidavit, but it doesn't need to go up
15:17:44 on the website.
15:17:48 And paragraph 121 indicates that
15:17:51 there was a Critical Incident Report filed with
15:17:56 the Ministry of Health and Long-Term Care on
15:17:59 March 15th, 2013. So if I can have document
15:18:06 00643 up.
15:18:10 And while we are doing that,
15:18:12 Commissioner, I was asked during the break if
15:18:15 we could note on the record that Exhibit 10
15:18:18 should be filed subject to redactions, so if we
15:18:22 can note that on Exhibit No. 10?
15:18:25 THE COMMISSIONER: Yes, thank
15:18:25 you. Exhibit 10 to be filed
15:18:29 subject to redactions.
15:18:34 Thank you for that, Counsel.
15:18:38 BY MS. HEWITT:
15:18:40 Q. This is a Critical Incident
15:18:44 Report, a critical incident of March 14th,

15:18:47 2013, the date and time first submitted is
15:18:51 March 15th, 2013, and the description of the
15:18:56 incident --
15:18:57 THE COMMISSIONER: Counsel, I'm
15:18:58 sorry to interrupt you, but is
15:19:00 this in the affidavit as well?
15:19:01 BY MS. HEWITT:
15:19:01 Q. Yes, it is at paragraph 121,
15:19:04 and the exhibit is at Exhibit EE, and it is the
15:19:12 first document. I apologize for that,
15:19:13 Commissioner, the first document.
15:19:15 It identifies that:
15:19:24 "During narcotic count by two
15:19:25 RNs at shift change between
15:19:28 evening shift and night shift it
15:19:30 was noted that 1 capsule of
15:19:37 Kadian SR 10 mg. was missing.
15:19:39 The narcotic count between day
15:19:41 and evening shift earlier in the
15:19:42 day was correct. It is possible
15:19:43 that resident may have received
15:19:44 a double dose as Bethe
15:19:48 Wettlaufer, RN reported that bin
15:19:51 was searched and capsule could
15:19:53 not be found."
15:20:00 And then over to "Actions
15:20:02 taken." And my understanding, Brenda, is that
15:20:04 for missing controlled substances, those have
15:20:07 to be reported to the Ministry; is that
15:20:10 correct?
15:20:10 A. Yes.
15:20:11 Q. And maybe if you can just

15:20:14 speak up a little. We are still having
15:20:16 problems.
15:20:16 A. Yes, I'm sorry.
15:20:17 Q. That is okay. And then under
15:20:25 "Actions taken" on the next page:
15:20:27 "B. Wettlaufer, RN notified the
15:20:30 manager on call at 00:36 [...]"
15:20:34 So again she was on night shift,
15:20:36 is that correct?
15:20:36 A. Yes.
15:20:39 "[...] which was myself, H.
15:20:41 Crombez. RN stated that there
15:20:43 was a delay in reporting as they
15:20:44 searched the lower drawer/bin
15:20:47 for the capsule but could not
15:20:48 find it. H. Crombez asked that
15:20:53 Police Department be notified
15:20:54 and investigate which was done.
15:20:56 Cst. Randy Rudy came to the
15:21:00 nursing home and interviewed
15:21:02 both B. Wettlaufer and L.
15:21:05 Durbidge." And it reports the
15:21:09 incident number.
15:21:10 "Resident was assessed at 00:50
15:21:14 by B. Wettlaufer, RN due to
15:21:17 possibility she may have
15:21:17 received an extra dose of
15:21:20 Kadian. Was easily roused, was
15:21:23 alert and conversant."
15:21:25 And then she goes on to give the
15:21:28 resident's vital signs and indicates that the
15:21:30 resident was monitored.

15:21:33 And then finally at page 3 under
15:21:38 "Analysis and follow-up":
15:21:40 "Memo to all registered staff
15:21:42 that starting immediately they
15:21:43 are to initial the bubble of
15:21:45 each medication that they pop
15:21:47 out of medication card. This
15:21:49 step is in addition to their
15:21:51 regular charting, recording and
15:21:53 counting of narcotics and
15:21:57 controlled substances. Incident
15:21:59 is being investigated and staff
15:22:01 are being interviewed.
15:22:03 Ongoing education regarding
15:22:07 medication administration,
15:22:08 following protocols for
15:22:09 narcotics and prompt reporting
15:22:10 of discrepancies."
15:22:12 You'll hear about narcotics,
15:22:16 narcotic storage, the bin, et cetera, through
15:22:18 the nursing witnesses, Commissioner, but in
15:22:21 respect of this particular incident, I
15:22:25 understand that Elizabeth Wettlaufer was given
15:22:29 a one-day suspension; is that correct?
15:22:31 A. That's correct.
15:22:31 Q. Is it your understanding that
15:22:34 there was no police charges laid in respect --
15:22:38 A. There was no police charges
15:22:39 laid.
15:22:39 Q. So that brings us then to
15:22:48 March 2014, and you'll recall just before the
15:22:57 break we were at the point that Bethe

15:23:01 Wettlaufer had been given a five-day suspension
15:23:04 in January of 2014. That suspension had been
15:23:11 grieved, and in March of 2014 there is another
15:23:19 medication error at this point in time.
15:23:24 Do you recall what that
15:23:26 medication error was, Brenda?
15:23:27 A. Yes.
15:23:28 Q. And what was the medication
15:23:29 error?
15:23:30 A. Bethe had loaded the wrong
15:23:34 insulin into an insulin pen and over the course
15:23:39 of a weekend a resident received the wrong
15:23:43 insulin.
15:23:44 Q. And my understanding, and in
15:23:47 fact, Commissioner, you will hear evidence from
15:23:50 the actual nurse that reported that the insulin
15:23:54 had to be replaced and then discovered the
15:23:56 error three days later, she will be testifying.
15:24:00 Her name is Agatha Krawczyk.
15:24:06 My understanding is that Bethe
15:24:08 Wettlaufer would not have worked three days, 24
15:24:12 hour shifts a day, for the next three days; is
15:24:14 that correct?
15:24:14 A. No, she did not.
15:24:15 Q. So it indicates within the
15:24:17 record that that resident was getting the wrong
15:24:19 insulin for a period of three days?
15:24:25 A. I believe so.
15:24:25 Q. At the time that you
15:24:26 terminated Bethe Wettlaufer, do you recall
15:24:29 whether or not you interviewed or Mrs. Crombez
15:24:33 interviewed the other staff that potentially

had given insulin in error?
A. No, I do not recall it.
Q. Now, you terminated Bethe Wettlaufer at this point in time?
A. Yes.
Q. Were you required to get head office authority to do that?
A. Yes. Yes, we did.
Q. Now, that termination letter, I won't refer you to it, Commissioner, but it is at exhibit number KK, and for the benefit of my friends, the other participants, the number is 16755.
Now, your affidavit indicates that Bethe Wettlaufer grieved her termination as well; is that correct?
A. That's correct.
Q. Now, before we get to what happened with that grievance, the evidence indicates that you did report this termination to the College of Nurses; is that correct?
A. Correct.
Q. Were you required to report -- I'm sorry, Madam -- were you required to report this to the College of Nurses?
A. Yes, we were.
Q. And why is that? Under what circumstances do you report a member or an employee to the College of Nurses?
A. I just know that all terminations of registered staff are reported to the College of Nurses.

15:26:25 Q. And who would have prepared
15:26:27 the Report Form for Facility Operators?
15:26:31 A. The report to the College of
15:26:33 Nurses?
15:26:33 Q. Correct.
15:26:34 A. Yes, me.
15:26:35 Q. All right. And if I can turn
15:26:40 to that document, which is at your Exhibit LL,
15:26:46 Commissioner, which is document number 16717,
15:27:17 is this the document that you would have filed
15:27:20 with the College of Nurses?
15:27:21 A. Yes.
15:27:25 Q. Is this an online filing
15:27:28 system or do you have to type it and send it
15:27:32 in; do you recall?
15:27:33 A. I don't recall.
15:27:34 Q. The document is dated --
15:27:37 A. I know that we obtained it
15:27:38 online and typed it on our computer online, but
15:27:43 then I don't know if we submitted it online. I
15:27:46 believe we mailed it in.
15:27:47 Q. The document itself is dated
15:27:51 March 31st, 2014.
15:27:56 A. Uhm-hmm.
15:27:56 Q. And your cover letter, and I
15:28:03 won't ask, Amanda, I won't ask you to go to it,
15:28:06 but the cover letter contained at that same tab
15:28:09 is dated April 17th, 2014, and that is the
15:28:14 cover letter where you enclose the Report Form?
15:28:18 A. Okay.
15:28:19 Q. Do you know why there is a
15:28:22 difference or a 17-day delay between the date

15:28:26 on the particular form and the date that it is
15:28:29 sent in to the College of Nurses?
15:28:31 A. I think that we were working
15:28:34 on that and during a very busy time and we -- I
15:28:41 wasn't familiar with the form. I remember, you
15:28:45 know, thinking I have to get this in, I have to
15:28:47 get it submitted. And I must have started it
15:28:50 March 31st and then completed it in April.
15:28:53 Q. And then it describes --
15:28:57 well, tell us what this document describes?
15:28:59 A. It describes dates and
15:29:04 events, consequences to the staff member, and a
15:29:12 brief explanation of how the staff member took
15:29:17 the discipline, because we described various
15:29:20 disciplines in this, and the actions taken.
15:29:24 So we started with the
15:29:26 termination and we worked back in her file to
15:29:31 report what was on her file for, I believe,
15:29:34 medication errors.
15:29:36 Q. All right.
15:29:37 A. Which led to her termination.
15:29:39 Q. And you said in the first one
15:29:42 where you were actually reporting her
15:29:44 termination, it says March 20, 2014, and we
15:29:51 know that the date of the termination is March
15:29:56 31st and that the date I believe in your
15:30:02 affidavit is the date that the Registered Nurse
15:30:06 actually left for the weekend and left the
15:30:09 insulin out. Where would you get these dates
15:30:11 from, generally speaking?
15:30:13 A. Probably off of the Progress
15:30:15 Notes, I would think.

15:30:20 Q. So are you reflecting there
15:30:22 then the date of the incident?
15:30:23 A. I'm not sure. I would have
15:30:24 to check back.
15:30:24 Q. And then you go through with
15:30:27 respect to the termination event, the five-day
15:30:32 suspension in January of 2014, the letter of
15:30:43 warning on poor work performance, all the way
15:30:48 down to August 29th, 2012:
15:30:58 "Written warning for not
15:30:59 assessing a resident when
15:31:01 required."
15:31:03 Is there a reason that you
15:31:04 stopped at 2012?
15:31:05 A. I think the form was full,
15:31:09 like, you know, no more pages came up, and then
15:31:12 I just added that there was more things on her
15:31:15 file. It is not a form that we -- I don't know
15:31:20 if this was my first one ever or not. I know I
15:31:25 have never in my career filled out very many of
15:31:28 them, so I think I felt that we had enough, you
15:31:34 know, referring enough to the College of Nurses
15:31:37 for them to do an investigation.
15:31:38 Q. And it states:
15:31:42 "There were other reports from
15:31:43 staff that did not lead to
15:31:44 discipline but were considered
15:31:46 at time of termination. These
15:31:49 reports had to do with
15:31:50 attendance, professional
15:31:52 behaviour."
15:31:53 Are those the issues that we

15:31:55 1 have been speaking about today?
15:31:55 2 A. I believe that is what I
15:31:56 3 meant by that.
15:31:57 4 Q. There is a letter from the
15:32:05 5 College of Nurses dated July 17th at document
15:32:11 6 number 16715, and that is Exhibit MM,
15:32:20 7 Commissioner. This document, this letter is
15:32:28 8 actually dated -- or actually addressed to
15:32:30 9 Helen Crombez. Would you have received a copy
15:32:33 10 of this letter or been notified by Mrs. Crombez
15:32:39 11 that it had been received?
15:32:40 12 A. I believe that Helen would
15:32:42 13 have, yes, brought it down to my office.
15:32:44 14 Q. It acknowledges the receipt
15:32:45 15 of the Report Form for Facility Operators and
15:32:49 16 in the second paragraph it states:
15:32:52 17 "Since all of the information
15:32:54 18 pertaining to this matter is
15:32:56 19 confidential, we are unable to
15:32:58 20 inform you of the proceedings or
15:33:01 21 outcome in relation to any
15:33:02 22 investigation which may ensue.
15:33:04 23 If further information is
15:33:07 24 required, an investigator of the
15:33:09 25 College will contact you at a
15:33:11 26 later date."
15:33:13 27 Were you ever contacted by the
15:33:16 28 College of Nurses, to the best of your
15:33:18 29 knowledge?
15:33:18 30 A. I have been called by the
15:33:23 31 College of Nurses on other matters, but I don't
15:33:27 32 believe I was called on this one.

15:33:28 Q. Now, Mrs. Crombez will talk
15:33:32 about a conversation that she had with the
15:33:34 College --
15:33:35 A. Yes, I believe they spoke
15:33:36 with Helen.
15:33:36 Q. All right. And did
15:33:40 Mrs. Crombez advise you as to the conversation
15:33:43 that had taken place at all?
15:33:44 A. I can't recall. That was a
15:33:47 lot of years ago and a lot less stress ago.
15:33:51 Q. And then after this, any
15:33:54 other correspondence or notification from the
15:33:57 College of Nurses as to how that particular
15:34:01 Report Form and termination was handled?
15:34:04 A. No, I haven't received
15:34:06 anything else.
15:34:06 Q. Now, there was still
15:34:15 outstanding, as I indicated before, two
15:34:18 grievances with respect to Elizabeth
15:34:23 Wettlaufer; one was in relation to her five-day
15:34:26 suspension and one was in relation to her
15:34:30 termination.
15:34:31 We do know from a review of the
15:34:33 file that Elizabeth Wettlaufer settled those
15:34:39 grievances. Were you involved at all in the
15:34:43 settlement of those grievances?
15:34:45 A. No, I was not.
15:34:46 Q. That is perhaps why it is not
15:35:01 in your affidavit. But I do want to ask you a
15:35:04 question, so if you just give me one more
15:35:06 moment, Commissioner.
15:35:09 THE COMMISSIONER: Yes.

15:35:09 1 BY MS. HEWITT:
15:35:33 2 Q. If I can pull up document
15:35:42 3 16710, which is in our OR report under
15:35:47 4 Caressant Care, which is Exhibit No. 6,
15:35:51 5 Commissioner. There's two documents it could
15:35:59 6 be, so I have a 50/50 chance that this is the
15:36:03 7 right one.
15:36:03 8 This will do for now. There is
15:36:52 9 a settlement amount of $2,000 that we know was
15:36:55 10 paid to Ms. Wettlaufer at the time that the
15:36:59 11 grievance was settled. Were you aware of the
15:37:02 12 actual payment of $2,000?
15:37:06 13 A. No, I was not.
15:37:08 14 Q. And there is also, if I can
15:37:10 15 go to 16709, this letter is dated June 11,
15:37:37 16 2014, and my understanding is that this letter
15:37:40 17 came out of the settlement of the grievance and
15:37:45 18 it states -- I see, Your Honour, I was actually
15:37:51 19 hoping that was the right document, but it is
15:37:52 20 not.
15:38:10 21 All right, just give us a
15:38:13 22 moment, Commissioner.
15:38:14 23 16712. We were in the vicinity,
15:38:53 24 Commissioner, just two away. Now, it is signed
15:39:10 25 by Wanda Sanginesi, and it indicates:
15:39:15 26 "This will confirm that Bethe
15:39:19 27 Wettlaufer was employed by
15:39:20 28 Caressant Care Nursing and
15:39:21 29 Retirement Homes at our nursing
15:39:24 30 home in Woodstock, Ontario from
15:39:26 31 June 27, 2007 to March 24, 2014
15:39:29 32 in the capacity of Registered

Nurse.
In this capacity she was responsible for the providing nursing care to our elderly residents and for supervising the work of RPNs and PSWs.
During her time with us Ms. Wettlaufer proved herself to be a good problem-solver with strong communication skills.
She was punctual and enjoyed sharing her knowledge with others.
Ms. Wettlaufer left our employ to pursue other opportunities.
We wish her well and are pleased to provide her with this reference."
Did you see this reference before it was sent?
A. No.
Q. Did anyone discuss with you, to the best of your recollection, the contents?
A. Not with me.
Q. So Bethe Wettlaufer is out of the facility as of March 24th. She is suspended, she's terminated March 31st, 2014.
What is the next that you hear of Ms. Wettlaufer?
A. I believe it was in October of 2016. I had retired September 30th, 2016. I called the home, spoke to Helen, and asked

her how things were going, and she just said, oh, Brenda, you don't want to know. And I said, what are you talking about? And she said, I couldn't call you, I don't even know if I should be telling you this, but there is a big police investigation going on. Bethe has confessed to murders.

I said, oh, Helen, come on. You know, what is wrong with her? Like, I said, does she want attention or what? I was -- and Helen just said, Brenda, it is true. We are looking this up with the police. They have asked us to keep it confidential until they get their initial investigation done.

And she said, it is true. So I did keep it to myself until, you know, the news release. I think maybe the day before the news release I told my family that there was going to be a news release and they'd better maybe come to my house, because they are going to be totally, totally shocked at what happened.

Q. Are you able to tell us a bit of what you were thinking at that time?

A. Disbelief. I felt so, so bad for those residents and their families, people that you welcome into your home and you say that, you know, we are going to care for your loved one. I think I was devastated and still am.

Q. And so the sequence was you retired just the week before?

A. Yes. I believe my retirement

15:43:06 1 party at Caressant Care was September 30th, and
15:43:13 2 I believe Helen said the police came on the
15:43:16 3 Monday, or even on the weekend there to confirm
15:43:19 4 that she had worked there.
15:43:25 5 And so it all happened right
15:43:26 6 around the same time, her confession, I don't
15:43:30 7 know if it was right around the time that I
15:43:32 8 retired and then the police came forward, yeah.
15:43:34 9 Q. Did you ever have a thought
15:43:37 10 at that time that she was intentionally harming
15:43:41 11 a resident?
15:43:42 12 A. Never.
15:43:43 13 Q. Anything looking back now?
15:43:47 14 A. You look at -- you look at
15:43:52 15 the evidence, the disciplines. You know, I'm
15:43:57 16 sure you are all sitting here thinking, well,
15:44:00 17 how could you not have reported this or not
15:44:02 18 report that. You have other nurses in your
15:44:05 19 facility, other staff in your facility, you are
15:44:09 20 dealing with so many things and you are trying
15:44:11 21 to do your job the best you can.
15:44:14 22 And no, even going back now to
15:44:18 23 those times, it didn't cross my mind that she
15:44:21 24 was harming residents. I do know and I do
15:44:27 25 believe one resident that she had an incident
15:44:33 26 with, and she later did inject her, was
15:44:41 27 probably because Helen and I had talked to her,
15:44:44 28 you know, about doing something wrong. Like,
15:44:46 29 it is --
15:44:47 30 Q. Is that Maureen Pickering?
15:44:49 31 A. Yes.
15:44:49 32 Q. So Maureen Pickering, the

15:44:51 1 incident was in January. You actually gave her
15:44:54 2 a five-day suspension at that point in time?
15:44:56 3 A. Yeah, and then, you know,
15:44:57 4 when did Maureen Pickering die? Like, it was
15:45:00 5 shortly after that.
15:45:02 6 Q. It was March, I believe.
15:45:03 7 A. In March, so, you know, was
15:45:05 8 she angry because -- you know, why did -- but
15:45:09 9 then why did she murder the other ones? Like,
15:45:12 10 why -- who was a victim and who wasn't? And
15:45:16 11 then there was the other resident we discussed
15:45:18 12 that they had numerous issues, and she didn't
15:45:22 13 kill them.
15:45:23 14 So no, I have -- I had no reason
15:45:27 15 to believe that she was harming residents.
15:45:30 16 Q. Can you speak a bit about the
15:45:35 17 impact it may have had on the home and on the
15:45:38 18 residents and yourself, if you have knowledge
15:45:40 19 of the impact on the home and the residents?
15:45:43 20 A. I went to the home, after it
15:45:45 21 was out on the news, and I didn't want to ask
15:45:50 22 the residents anything, you know, because I
15:45:52 23 thought if they don't understand or they don't
15:45:54 24 remember it, you know, why would I upset them,
15:45:57 25 but certain residents would stop me in the
15:46:00 26 hallway and they would say oh, Brenda, you are
15:46:02 27 back, and did you hear, did you hear? And they
15:46:06 28 were like -- I remember the one lady saying to
15:46:08 29 me, I would have never thought that of her, I
15:46:11 30 would have never ever thought that of her.
15:46:13 31 And I just said, I didn't
15:46:15 32 either. You know, I hugged her and gave her a

15:46:17 kiss and said, no, I never would have thought
15:46:21 that either.
15:46:22 The staff, I seen staff there in
15:46:23 the home that day. There was a lot of hugs,
15:46:28 and just disbelief, shock. And then I saw some
15:46:34 of the PSWs. When my grandchildren
15:46:38 figure-skate in Norwich, I seen some of the
15:46:41 PSWs there, and they just said afterwards, they
15:46:43 said, you know, we were all in such shock, but
15:46:48 we bonded closer together, you know, we know we
15:46:52 are a good home, we know we give good care.
15:46:55 And they said, you know, if
15:46:56 anything, she has made us a better, stronger
15:47:00 place. They said, the Ministry is there now
15:47:04 and we are just like terrified of everything we
15:47:07 do. Like, we are just being watched so
15:47:11 closely. And they said, we understand that,
15:47:13 but they said it is awful. They just -- you
15:47:17 know, it was so hard on them.
15:47:21 For myself, I don't know, I said
15:47:23 it in my statement and, you know, it isn't
15:47:28 about me. It isn't that --
15:47:34 Q. Do you want a break?
15:47:35 A. No.
15:47:38 THE COMMISSIONER: Just have a
15:47:38 little sip of water there.
15:47:50 THE WITNESS: I don't know if I
15:47:51 can swallow it.
15:47:52 THE COMMISSIONER: That is why
15:47:55 it works.
15:47:57 THE WITNESS: It is not about
15:47:58 me, but it is like your whole

15:48:00 career where you thought you did
15:48:02 so good a job, or tried to do
15:48:05 the best job you could, and it
15:48:08 ends like this.
15:48:11 I'm glad that I am a part of
15:48:14 this investigation and I am glad
15:48:16 that we are doing it.
15:48:19 Everything does need to come
15:48:20 forward. But it is still those
15:48:24 poor families and I wanted to
15:48:29 start today with saying to the
15:48:30 families, to give them my
15:48:32 deepest sympathy. And I have
15:48:35 had two significant losses in my
15:48:37 life. My kids were orphaned
15:48:42 twice, both dads, and I know the
15:48:46 pain we went through and still
15:48:49 go through.
15:48:50 But it can't compare, it can't
15:48:54 compare to somebody coming to
15:48:55 your door and saying your mom or
15:48:58 dad was murdered, you know, in a
15:49:00 nursing home where they should
15:49:01 be safe.
15:49:04 So will I ever get over it? I'm
15:49:07 not sure. But I do have a good
15:49:09 family and good friends, and,
15:49:14 you know, I will go on. And I
15:49:17 hope the families and the
15:49:18 victims of her can do the same
15:49:21 in time.
15:49:24 MS. HEWITT: Thank you. Those

15:49:25 are my questions.
15:49:28 THE COMMISSIONER: What is the
15:49:29 recommendation about whether we
15:49:31 start today on the
15:49:34 cross-examination?
15:49:36 MR. ZIGLER: Mr. Golden, it is
15:49:38 his witness as well, so he is
15:49:40 not cross-examining.
15:49:44 THE COMMISSIONER: All right.
15:49:46 MR. GOLDEN: I think it would be
15:49:47 appropriate to give Brenda a
15:49:48 break and there's going to be
15:49:50 quite a few lawyers asking her
15:49:52 questions, and my suggestion is
15:49:54 we give her the break and start
15:49:55 it in the morning.
15:49:56 THE COMMISSIONER: Are you happy
15:49:59 with that?
15:50:00 THE WITNESS: You know what, if
15:50:02 you want to get started, I am
15:50:04 fine. I will be fine.
15:50:07 THE COMMISSIONER: It is going
15:50:08 to be a long day tomorrow, so
15:50:11 how long did you think you were
15:50:12 going to be, Mr. Golden?
15:50:14 MR. GOLDEN: I am going to be a
15:50:16 very few minutes. I just have a
15:50:20 couple, a handful of questions.
15:50:22 I think it is a number of the
15:50:23 other lawyers that plan to be
15:50:24 longer.
15:50:25 THE COMMISSIONER: All right.

15:50:26 And so with that in mind,
15:50:27 because I understand the tenor
15:50:28 of the questioning is going to
15:50:29 change, do you think it is
15:50:31 better to go ahead? The witness
15:50:35 has said she is ready to proceed
15:50:37 if we are.
15:50:38 MR. GOLDEN: Sure, yeah.
15:50:39 THE COMMISSIONER: All right.
15:50:41 EXAMINATION IN-CHIEF BY MR.
15:50:41 GOLDEN:
15:50:42 Q. Thank you, Brenda. I know
15:50:44 that you have told the story in the affidavit,
15:50:45 and I know that you have given a lot of answers
15:50:50 today to questions from Ms. Hewitt and I just
15:50:56 wanted to clarify a couple of things.
15:50:59 In reviewing the affidavit and
15:51:01 in hearing you today, it seems that over the
15:51:03 almost seven years that Elizabeth Wettlaufer
15:51:09 worked at Caressant Care in Woodstock, the only
15:51:11 complaint that we could see from a family had
15:51:14 to do with that incident with the urine sample.
15:51:18 Do you recall other complaints
15:51:19 from families about how Elizabeth Wettlaufer
15:51:23 was treating them or residents?
15:51:26 A. No, I don't remember any
15:51:32 other.
15:51:34 Q. And the residents who also
15:51:38 would have had an opportunity to complain if
15:51:41 they felt mistreated by Ms. Wettlaufer, we
15:51:46 heard today a couple of complaints, so there
15:51:48 was the incident of the slapping and an

15:51:52 incident with the gentleman.
15:51:54 Other than what is in your
15:51:55 affidavit, do you have a recollection over the
15:51:57 years that you worked as Administrator of
15:52:03 residents coming forward to complain about how
15:52:05 they were treated by Elizabeth Wettlaufer,
15:52:08 other than what is in your affidavit?
15:52:10 A. No, I don't have any other --
15:52:15 I can't recall any other residents. I don't
15:52:18 recall residents complaining about her, other
15:52:21 than those incidences that we dealt with.
15:52:24 Q. And from the time, the period
15:52:27 of time that you worked as Administrator from
15:52:30 that 2009 until Ms. Wettlaufer's employment was
15:52:36 terminated in 2014, did you personally ever
15:52:39 observe her acting in a manner which suggested
15:52:42 to you that she was abusing alcohol or drugs?
15:52:46 A. No, I never suspected her of
15:52:50 abusing alcohol or drugs.
15:52:53 Q. And were there staff who
15:52:55 complained to you that she appeared to be under
15:52:58 the influence of alcohol or drugs while she was
15:53:00 working?
15:53:01 A. No, I don't recall that.
15:53:03 Q. And is it fair to say that
15:53:10 with respect to medication errors, and we have
15:53:14 seen a record here of the medication errors
15:53:16 that were made by Elizabeth Wettlaufer, were
15:53:20 there other nurses who would also have been
15:53:23 making med errors over this same period of
15:53:27 time?
15:53:28 A. Oh, yes, there was other

15:53:31 1 medication errors, yes.
15:53:34 2 MR. GOLDEN: All right, I have
15:53:35 3 nothing further. Thank you.
15:53:36 4 THE COMMISSIONER: Thank you
15:53:36 5 very much, Mr. Golden.
15:53:38 6 All right, so again, I'm in your
15:53:42 7 hands whether we should carry
15:53:45 8 on.
15:53:47 9 MR. ZIGLER: We have an order of
15:53:50 10 cross-examination. We have the
15:53:52 11 families, Mr. Scott and Mr. Van
15:53:56 12 Kralingen would be next. The
15:53:57 13 question is do we proceed now or
15:53:59 14 tomorrow.
15:54:04 15 Really, if the witness is up to
15:54:08 16 it, I would suggest we use the
15:54:09 17 time we have, because we are so
15:54:11 18 limited on time.
15:54:12 19 THE COMMISSIONER: Yes.
15:54:16 20 MR. SCOTT: Your Honour, I was
15:54:18 21 going to suggest we actually
15:54:19 22 move the cross-examinations
15:54:20 23 until tomorrow, but if the
15:54:21 24 witness wants to go on, my
15:54:23 25 friend and I, we may have very,
15:54:24 26 very similar questions. If we
15:54:26 27 have a little time to speak
15:54:28 28 while somebody else is
15:54:29 29 cross-examining, we might be
15:54:31 30 able to condense our questions
15:54:32 31 down and have one of us ask on
15:54:34 32 cross.

15:54:35 THE COMMISSIONER: All right.
15:54:39 MR. SCOTT: Just to speed it up.
15:54:42 MR. ZIGLER: The Ministry group
15:54:43 are next.
15:54:44 THE COMMISSIONER: How long is
15:54:45 the Ministry? How long does the
15:54:49 Ministry anticipate it will be?
15:54:51 MR. KLOEZE: Commissioner, Ms.
15:54:52 Parker will be asking the
15:54:53 questions. I don't think we'll
15:54:54 be more than 15 or 20 minutes.
15:54:58 THE COMMISSIONER: Then again,
15:55:01 if you are up to it, it may be
15:55:03 better to have a bit more of it
15:55:05 over today, frankly, for
15:55:06 everybody's sake. It could make
15:55:09 it a little bit less stress
15:55:11 tomorrow for you.
15:55:15 THE WITNESS: I don't think I'll
15:55:16 be able to sleep tonight.
15:55:17 THE COMMISSIONER: I'm not
15:55:18 guaranteeing any sleep tonight,
15:55:19 I can't do that, but I can say
15:55:21 that if you get some of the
15:55:22 cross-examination over today --
15:55:23 THE WITNESS: I'm good for
15:55:24 another 20 minutes or so.
15:55:26 THE COMMISSIONER: All right.
15:55:29 CROSS-EXAMINATION BY MS. PARKER:
15:55:35 Q. Hi, Ms. Van Quaethem. My
15:55:39 name is Judith Parker, I'm one of the lawyers
15:55:44 here who is representing Ontario, and I just

15:55:46 1 have a few questions for you. They mostly
15:55:48 2 arise out of your affidavit, and I think you
15:55:50 3 still have a copy of your affidavit in front of
15:55:51 4 you?
15:55:52 5 A. Yes, I do.
15:55:53 6 Q. So I just wanted to make sure
15:55:55 7 I understood that as the Administrator in the
15:55:58 8 home, you are the person in charge overall of
15:56:02 9 the running of the home; is that correct?
15:56:04 10 A. Correct.
15:56:04 11 Q. And what kind of training did
15:56:07 12 you receive to have that role at Caressant
15:56:10 13 Care? I understand that you told us earlier
15:56:14 14 that you had taken the Administrator's course
15:56:17 15 prior to joining Caressant Care, but after that
15:56:18 16 time, could you tell us something about any
15:56:21 17 training opportunities that you had about being
15:56:24 18 the Administrator of a long-term care home?
15:56:26 19 A. There wasn't any.
15:56:28 20 Q. Okay. Were there internal
15:56:36 21 learning days or -- I think you had mentioned
15:56:38 22 something about corporate days at --
15:56:41 23 A. Yes, we had corporate days
15:56:42 24 where, you know, there might be a little mini
15:56:47 25 presentation on some type of education. You
15:56:53 26 know, when Bill 168 came in, there was training
15:56:57 27 for, you know, the harassment and bullying.
15:57:06 28 Yes, there was training. I don't know about
15:57:12 29 any formal training. I think I went to a
15:57:21 30 general persuasion course, which the PSWs even
15:57:23 31 took, that type of training.
15:57:26 32 Q. I think you mentioned that

15:57:28 you had been through the big transition from
15:57:30 the old Nursing Homes Act to the new Long-Term
15:57:34 Care Home Act, that brought in some changes.
15:57:36 Were you given any opportunity to learn about
15:57:38 those changes or how did you learn about them?
15:57:40 A. I think we went to a day
15:57:46 session, maybe it was a two-day session in
15:57:49 Kitchener, to learn about the new regulations,
15:57:56 an overview, and you pretty well, you know,
15:58:02 looked it up on your own and learned the
15:58:04 regulations as you went along.
15:58:05 Q. As I understand it, Caressant
15:58:16 Care has a licence to operate the long-term
15:58:19 care beds at Caressant Care Woodstock; is that
15:58:21 your understanding?
15:58:21 A. Yes, it is.
15:58:22 Q. And I know that as a
15:58:26 licensee, Caressant Care has a number of duties
15:58:28 that it has to fulfill, and I wanted to ask you
15:58:31 a little bit about those. It is my
15:58:35 understanding that Caressant Care has a duty to
15:58:37 ensure a safe and secure home for the
15:58:41 residents; is that your understanding?
15:58:42 A. Yes, it is.
15:58:42 Q. And I understand that as a
15:58:48 part of that duty, there are a number of
15:58:50 different tasks that the home has to ensure are
15:58:55 completed. One of them, for example, would be
15:58:56 screening the staff before they are hired. Is
15:58:59 that something that you took care of?
15:59:01 A. Not for the nursing
15:59:05 department.

15:59:05 1 Q. Did you do it for other
15:59:10 2 staff?
15:59:10 3 A. I was responsible for hiring
15:59:16 4 managers or like the housekeeping department,
15:59:21 5 those type of staff.
15:59:21 6 Q. And what kinds of screening
15:59:24 7 did you do for those staff?
15:59:25 8 A. Well, we would ask for a
15:59:28 9 police report on them and a letter of reference
15:59:35 10 from a previous employment place.
15:59:37 11 Q. And to your knowledge, who
15:59:40 12 was it who had hired the nursing staff? I
15:59:42 13 think in your affidavit you had said that was
15:59:44 14 Ms. Crombez?
15:59:45 15 A. Yes, the Director of Nursing.
15:59:47 16 Q. And the process was the same,
15:59:49 17 as I understand it from your affidavit, that
15:59:51 18 there was screening for those individuals?
15:59:53 19 A. Yes.
15:59:53 20 Q. I also understand that
15:59:57 21 Caressant Care had a duty to ensure that the
15:59:59 22 rights of the residents are respected?
16:00:01 23 A. Yes.
16:00:02 24 Q. And I understand that there
16:00:06 25 has to be a mechanism for the residents to be
16:00:08 26 made aware of their rights in the home. Can
16:00:11 27 you tell me a little bit about how that worked
16:00:13 28 at Caressant Care Woodstock?
16:00:14 29 A. Yes, that was done through
16:00:17 30 the residents' council. They -- we would teach
16:00:29 31 them the resident -- go through the Bill of
16:00:33 32 Rights and teach them, you know, give them

16:00:35 documents. It was provided in their admission
16:00:40 packages. There was -- we had TV -- I don't
16:00:44 know what the system is, but it is like TV
16:00:46 monitors throughout the home, and we would post
16:00:48 the residents' rights on there. Usually we
16:00:52 would try to change that, you know, every week
16:00:54 or something, so, you know, they weren't
16:00:56 bombarded with all the rights at once.
16:00:58 And yes, we did different things
16:01:01 for that.
16:01:01 Q. And as a licensee, Caressant
16:01:09 Care would have the duty also to protect
16:01:11 residents from abuse and also to ensure that
16:01:14 its staff don't neglect any of the residents?
16:01:17 A. Correct.
16:01:17 Q. And my understanding is there
16:01:22 is a requirement to have a written policy about
16:01:24 the prevention of neglect and abuse?
16:01:27 A. We had a policy.
16:01:29 Q. Was that something that you
16:01:30 developed?
16:01:30 A. No, it was developed at head
16:01:32 office. Our policies were developed at head
16:01:34 office.
16:01:35 Q. And how did the staff know
16:01:39 about the policy?
16:01:40 A. All staff were given access
16:01:44 to the policies, and at one time they were in a
16:01:50 manual form and then they went online and staff
16:01:54 were given -- I can't think of the name of the
16:01:59 system now. Like, when I left there and
16:02:01 retired, I pretty well let my brain filter out,

16:02:05 so I can't think of the name of the document
16:02:12 website, but there was a website that they
16:02:13 could go on.
16:02:14 Q. And were you trained on that
16:02:15 policy?
16:02:15 A. Yes.
16:02:17 Q. Obviously, as part of the
16:02:23 duty to protect the residents from neglect,
16:02:27 there is an obligation to report certain
16:02:29 incidents, and we talked about that today --
16:02:31 A. Yes.
16:02:31 Q. -- to the Ministry. And I
16:02:33 just wanted to turn quickly to paragraph 16 of
16:02:36 your affidavit, if I could, it is on page 5.
16:02:51 There's a few examples under paragraph 16 of --
16:02:57 thank you, Amanda for bringing it up. So I
16:03:00 think it is page 5 of the PDF as well. Yes.
16:03:02 There are a few examples listed
16:03:04 here of things that need to be reported to the
16:03:06 Ministry.
16:03:07 A. Uhm-hmm.
16:03:07 Q. And you will see the first
16:03:09 one is:
16:03:09 "Improper or incompetent
16:03:11 treatment [...]"
16:03:12 And the second is:
16:03:13 "Abuse of a resident or neglect
16:03:15 of a resident [...]"
16:03:19 And I just wanted to make sure,
16:03:21 in the preamble to that it says:
16:03:23 "We were required to immediately
16:03:25 report such things [...]"

16:03:27 1 It is my understanding that
16:03:29 2 anyone who is aware of any of those first three
16:03:32 3 items has an obligation to report them to the
16:03:34 4 Ministry directly. Is that how it worked at
16:03:36 5 Caressant Care?
16:03:36 6 A. You mean anyone? Normally it
16:03:42 7 was Helen or I that did the reporting.
16:03:45 8 Q. All right.
16:03:46 9 A. Other managers, managers were
16:03:48 10 trained on the Critical Incident System, but
16:03:51 11 they weren't comfortable with it, so it was
16:03:54 12 usually Helen and I.
16:03:55 13 Q. Okay. And another example
16:04:02 14 that is not listed here but I think might be
16:04:06 15 worth speaking about is that it is my
16:04:09 16 understanding there is also an obligation to
16:04:11 17 alert the Ministry if there is a medication
16:04:13 18 incident or an adverse drug reaction that may
16:04:18 19 cause a resident to go to hospital. Was that a
16:04:23 20 kind of report that you would make from time to
16:04:26 21 time, if there was a medication incident that
16:04:29 22 required --
16:04:30 23 A. I wouldn't do that so much
16:04:33 24 myself. I wouldn't be the one doing that. It
16:04:35 25 would be the Director of Nursing.
16:04:36 26 Q. The Director of Nursing,
16:04:41 27 okay, great, I will ask Helen Crombez about
16:04:41 28 that tomorrow.
16:04:41 29 Just below that, you speak about
16:04:48 30 how the Ministry may, as a result of a Critical
16:04:55 31 Incident Report, come and conduct a critical
16:04:57 32 incident inspection. It is my understanding

16:04:59 1 that in addition to that, Caressant Care
16:05:03 2 Woodstock would conduct its own investigation;
16:05:06 3 is that normally what would happen? If there
16:05:08 4 was a critical incident, you would investigate
16:05:10 5 those incidents?
16:05:12 6 A. Yes, we would.
16:05:13 7 Q. On the previous page, on page
16:05:26 8 15, in discussing the process for dealing with
16:05:30 9 complaints, I noticed that at paragraph 15 you
16:05:40 10 had noted that in the second sentence:
16:05:42 11 "Written complaints received by
16:05:43 12 us were reported to Head Office
16:05:46 13 [...]"
16:05:46 14 I wonder if you know what was
16:05:48 15 done with the written complaints when they were
16:05:51 16 sent to your head office?
16:05:52 17 A. I think it was just to advise
16:05:53 18 them that we received a written report, and
16:05:57 19 then they would -- you know, if there was
16:06:00 20 advice to be given to us in how to deal with
16:06:03 21 it, they would help us.
16:06:04 22 Q. I just have a couple more
16:06:11 23 questions.
16:06:12 24 As you will recall, Ms. Hewitt
16:06:16 25 was asking you about various incidents
16:06:17 26 involving Elizabeth Wettlaufer, including
16:06:19 27 matters that led to discipline in the home or
16:06:22 28 complaints among staff members.
16:06:24 29 It is my understanding that not
16:06:27 30 all of the issues involving Ms. Wettlaufer are
16:06:30 31 the kinds of things that you are required to
16:06:32 32 advise the Ministry about. Is that your

16:06:35 1 understanding? So for example, if the staff
16:06:39 2 weren't getting along, is that something that
16:06:41 3 you would report to the Ministry?
16:06:42 4 A. No.
16:06:43 5 Q. And it is the employer,
16:06:54 6 Caressant Care, who is responsible for dealing
16:06:57 7 with staff relations issues and discipline, is
16:07:04 8 that right, as compared to the Ministry?
16:07:08 9 A. Well, we would deal with it.
16:07:09 10 Q. Okay, that is great.
16:07:11 11 Thank you, those are all of my
16:07:13 12 questions.
16:07:14 13 A. Okay, thank you.
16:07:15 14 Q. You are welcome.
16:07:19 15 THE COMMISSIONER: Okay.
16:07:24 16 MR. ZIGLER: I think the next on
16:07:25 17 the list is ONA.
16:07:29 18 MS. HUGHES: Madam Chair, I
16:07:31 19 would very much like to go after
16:07:32 20 the family in the order that we
16:07:34 21 have agreed to.
16:07:35 22 THE COMMISSIONER: Well, it is
16:07:41 23 20 after 4:00. Sorry, am I
16:07:43 24 wrong? Oh, 10 after 4:00. I
16:07:45 25 needed my glasses for that one.
16:07:47 26 So I don't know if you had a
16:07:50 27 chance to confer or --
16:07:55 28 MR. VAN KRALINGEN: Not during
16:07:56 29 those moments, no.
16:07:57 30 THE COMMISSIONER: No, I thought
16:07:58 31 I saw Mr. Scott lean over and
16:08:00 32 speak to you, so I wasn't sure

16:08:02 if there had been any progress
16:08:04 there.
16:08:04 Well, if ONA prefers to come
16:08:07 after the family, I think we
16:08:08 have to respect the order in
16:08:10 which the questioning is to
16:08:12 happen. If I understood your
16:08:14 submissions, Mr. Scott, earlier
16:08:16 you felt that if you had an
16:08:18 opportunity to spend some time
16:08:19 with Mr. Van Kralingen, it is
16:08:21 possible that some of the
16:08:22 questioning would be shortened;
16:08:24 is that fair?
16:08:25 MR. SCOTT: Absolutely. I
16:08:26 suspect we are going to ask very
16:08:29 much the same questions.
16:08:30 THE COMMISSIONER: Then I think
16:08:31 this would be an appropriate
16:08:32 time, unless I hear something
16:08:33 different, I think this would be
16:08:34 an appropriate time to take the
16:08:35 recess and start again tomorrow
16:08:37 morning.
16:08:40

-- Adjourned at 4:08 p.m.

REPORTER'S CERTIFICATE

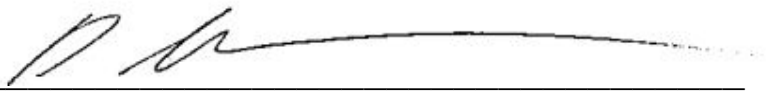
I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify;

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 6th day of June, 2018



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