

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

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DAY 31 / VOL 31  
August 03, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

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--- This is Day 31/Volume 31 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 3rd day of August, 2018, commencing at 9:30 a.m.

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BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

REPORTED BY: Deana Santedicola, CSR, CRR, RPR  
& Carissa Stabblers, RPR, CSR

1     A P P E A R A N C E S:  
2  
3     & Megan Stephens, Esq.,       Commission Counsel  
4     & Alexandra Campbell, Esq.,  
5     & Lara Kinkartz, Esq.,  
6     & Etienne Lacombe, Student-at-Law  
7     & Sean Pierce, Student-at-Law  
8     & Gregory Furmaniuk, Student-at-Law  
9  
10    David M. Golden, Esq.,        Caressant Care  
11                                    Nursing and  
12                                    Retirement Homes  
13                                    Limited, Caressant  
14                                    Care - Woodstock  
15  
16    Denise Cooney, Esq.,         College of Nurses  
17  
18    Paul H. Scott, Esq.,         Jon Matheson,  
19                                    Pat Houde,  
20                                    Beverly Bertram  
21  
22    Darrell Kloeze, Esq.,        Her Majesty the  
23    & Alexa Mingo, Esq.,         Queen in Right of  
24    & Kristin Smith, Esq.,        Ontario  
25    & Meagan Williams, Esq.,  
26  
27    Nicole Butt, Esq.,            Ontario Nurses  
28                                    Association  
29  
30    Jane Meadus, Esq.,            Advocacy Centre  
31    & Suzan Fraser, Esq.,         for the Elderly  
32

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

Jennifer L. McAleer, Esq., Revera Long-Term  
Care Inc.

Lisa Corrente, Esq., Jarlette Health  
Services, Meadow  
Park (London) Inc.  
o/a Meadow Park  
London Long-Term  
Care

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09:20:27 1 -- Upon commencing at 9:30 a.m.

09:25:02 2  
09:30:12 3 MS. STEPHENS: Good morning,  
09:30:14 4 Commissioner.

09:30:14 5 As you know, Ms. Moroney is  
09:30:18 6 back, back for her counsel's  
09:30:20 7 examination and then also for  
09:30:21 8 cross-examination.

09:30:22 9 But with the approval and  
09:30:27 10 okay of all counsel, there was  
09:30:29 11 one remaining document that I  
09:30:30 12 did want to ask Ms. Moroney  
09:30:32 13 about. This is not yet an  
09:30:37 14 exhibit at trial, but I would  
09:30:41 15 like to ask Ms. Moroney about  
09:30:43 16 this.

09:30:43 17 NATALIE MORONEY; Under Prior  
09:30:43 18 Oath.

09:30:43 19 EXAMINATION IN-CHIEF BY  
09:30:43 20 MS. STEPHENS (CONT'D):

09:30:44 21 Q. Natalie, during the course of  
09:30:46 22 your inspections, you typically will prepare a  
09:30:51 23 Staff Inventory List; is that correct?

09:30:52 24 A. Yes.

09:30:53 25 Q. And this is a list of who you  
09:30:54 26 plan on interviewing?

09:30:55 27 A. This is the list of the staff  
09:30:58 28 inventory that we did interview.

09:31:01 29 Q. That you did interview. And  
09:31:02 30 then the staff are given basically an anonymous  
09:31:06 31 number; is that correct?

09:31:06 32 A. Correct.

09:31:07 1 Q. Okay, and then that, in your  
09:31:09 2 report, you ultimately end up referring to  
09:31:11 3 staff members by that number?

09:31:13 4 A. Correct.

09:31:14 5 Q. Okay. And is this the Staff  
09:31:19 6 Inventory List that was prepared during the  
09:31:19 7 course of the Meadow Park inspection that we  
09:31:21 8 discussed yesterday?

09:31:22 9 A. Yes.

09:31:23 10 MS. STEPHENS: Okay. So,  
09:31:25 11 Commissioner, I would like to  
09:31:28 12 ask that this be made the next  
09:31:29 13 exhibit at the Inquiry, and the  
09:31:32 14 reason for that is it helps us  
09:31:33 15 make sense of all the Inspection  
09:31:35 16 Reports so that we can see which  
09:31:37 17 staff members Natalie spoke with  
09:31:41 18 and just make sense of that  
09:31:42 19 report, particularly in light of  
09:31:44 20 the Facilities Phase where many  
09:31:46 21 of those people testified. It  
09:31:48 22 will just help us make sense of  
09:31:49 23 it going forward.

09:31:50 24 It probably should have been  
09:31:51 25 included in our Overview Report  
09:31:53 26 and was included in the case of  
09:31:56 27 Caressant Care.

09:31:57 28 THE COMMISSIONER: All right,  
09:31:58 29 thank you very much. And all  
09:32:00 30 the other counsel have seen this  
09:32:01 31 and no problems, right?

09:32:03 32 Thank you.



09:32:03 1 Madam Clerk, am I right in  
09:32:06 2 understanding that would be  
09:32:07 3 Exhibit 142?  
09:32:09 4 THE COURT CLERK: 143.  
09:32:11 5 THE COMMISSIONER: 143. What  
09:32:15 6 was 142?  
09:32:18 7 THE COURT CLERK: That was the  
09:32:19 8 Affidavit of Natalie Moroney.  
09:32:20 9 THE COMMISSIONER: Oh, yes,  
09:32:21 10 okay, thank you.  
09:32:21 11 Exhibit 143 then, a several-page  
09:32:25 12 document that is a Staff  
09:32:27 13 Inventory List, Date of  
09:32:29 14 Inspection October 28, 2016.  
09:32:25 15 EXHIBIT NO. 143: Staff  
09:32:27 16 Inventory List, Date of  
09:32:29 17 Inspection October 28, 2016.  
09:32:32 18 THE COMMISSIONER: So we don't  
09:32:33 19 have any redaction issues with  
09:32:34 20 this exhibit?  
09:32:38 21 MS. STEPHENS: There have  
09:32:38 22 been -- we have not redacted  
09:32:40 23 staff names throughout, so that  
09:32:41 24 is not an issue.  
09:32:42 25 The only redactions that  
09:32:43 26 appear there are ones that we  
09:32:45 27 agreed to. They were legal  
09:32:47 28 counsel, not actually staff at  
09:32:48 29 the home.  
09:32:49 30 THE COMMISSIONER: All right,  
09:32:49 31 thank you.  
09:32:50 32 Thank you.

09:32:53 1 MS. STEPHENS: And those are my  
09:32:54 2 one wrap-up question. Thank  
09:32:55 3 you, Madam Commissioner.  
09:32:57 4 THE COMMISSIONER: Thank you  
09:32:57 5 very much.  
09:32:59 6 EXAMINATION IN-CHIEF BY  
09:32:59 7 MS. MINGO:  
09:33:05 8 Q. Good morning, Madam  
09:33:07 9 Commissioner.  
09:33:07 10 Good morning, Natalie.  
09:33:08 11 A. Good morning.  
09:33:09 12 Q. I wanted to ask you, we heard  
09:33:12 13 yesterday that before joining the Ministry, you  
09:33:14 14 had worked as a RAI Coordinator in a home?  
09:33:17 15 A. Yes, I did.  
09:33:17 16 Q. And we have heard some other  
09:33:19 17 testimony through this proceeding about the  
09:33:24 18 RAI/MDS system, and we have heard some  
09:33:25 19 testimony about how it feeds into the  
09:33:27 20 Ministry's funding, but I wanted to ask you  
09:33:28 21 about how RAI/MDS is used in long-term care  
09:33:31 22 homes.  
09:33:31 23 So I understand that RAI/MDS  
09:33:34 24 data is used to develop the Plan of Care for  
09:33:37 25 each resident?  
09:33:37 26 A. Yes, that's correct.  
09:33:38 27 Q. Can you tell us how that  
09:33:39 28 works?  
09:33:40 29 A. If you think of the RAI/MDS  
09:33:42 30 as a preliminary screening process, there are  
09:33:46 31 questions that the registered staff or the RPN  
09:33:50 32 in the home or the RAI Coordinator who could be

09:33:53 1 an RN or an RPN would complete. So they are  
09:33:55 2 gathering data from observation, health care  
09:33:58 3 records and interviewing the resident.

09:34:01 4 Once the RAI/MDS is complete,  
09:34:04 5 there are triggers, and those triggers are  
09:34:06 6 identified as RAPs, which are the Resident  
09:34:12 7 Assessment Protocols. The Resident Assessment  
09:34:15 8 Protocols identify care areas or any concerns  
09:34:17 9 that could be potential problems for the  
09:34:18 10 residents, any needs that the resident requires  
09:34:21 11 and any preferences.

09:34:26 12 I believe there is 18 RAPs, so  
09:34:30 13 the Resident Assessment Protocols, and some of  
09:34:32 14 those could be delirium, cognition,  
09:34:36 15 communication, falls, continence care, et  
09:34:39 16 cetera.

09:34:40 17 So for an example, during the  
09:34:42 18 preliminary process, if the nurse has checked  
09:34:44 19 off the box in section "J" of the RAI/MDS  
09:34:46 20 assessment, so if the resident has had a fall  
09:34:50 21 in the last 30 days, once the assessment is  
09:34:52 22 closed, the RAPs are generated and then it will  
09:34:55 23 show a triggered area of care.

09:34:58 24 So for the RAPs, there might  
09:35:00 25 have also been some other issues where the  
09:35:03 26 resident experienced an infection, so if the  
09:35:05 27 resident was having a urinary tract infection,  
09:35:08 28 that would also be identified in the RAI/MDS  
09:35:10 29 assessment in the preliminary screening  
09:35:12 30 process. And often you will see with a  
09:35:14 31 resident who might have a urinary tract  
09:35:16 32 infection, there could be causes of delirium,

09:35:17 1 so some confusion, unbalanced, unsteady gait.

09:35:22 2 So when the nurse is creating  
09:35:24 3 the RAP, they are identifying all of these  
09:35:27 4 areas and they are kind of pulling all that  
09:35:29 5 information together, and it creates a picture  
09:35:31 6 of what was happening at that time for the  
09:35:33 7 resident.

09:35:34 8 Those identified areas then  
09:35:37 9 would move into the resident's Care Plan, and  
09:35:39 10 the Care Plan is individual and it is very  
09:35:42 11 specific to those residents in the home and it  
09:35:46 12 identifies, again, any care concerns, if there  
09:35:49 13 is improvements that could be made in the  
09:35:51 14 goal-setting. So a resident that had a fall  
09:35:53 15 with a fractured hip, you'll have restorative  
09:35:56 16 care involved. They might be walking them for  
09:35:59 17 15 minutes a day. It is resident-specific.

09:36:03 18 The Care Plan also gives  
09:36:05 19 direction to the frontline staff, so Personal  
09:36:09 20 Support Workers have access to the Care Plan or  
09:36:11 21 they have access to Point Click Care, which is  
09:36:14 22 a computerized system, that will tell them how  
09:36:18 23 to direct their care for that resident. It  
09:36:20 24 will let them know and identify any safety  
09:36:22 25 concerns, so if a resident is at risk for  
09:36:25 26 falls, the interventions that might be in place  
09:36:27 27 for that resident would be a high/low bed.  
09:36:29 28 They require a chair alarm to alert staff if  
09:36:32 29 they are trying to stand up on their own and  
09:36:34 30 they shouldn't be.

09:36:35 31 For us, when we go in as  
09:36:37 32 Inspectors, we do look at the RAI/MDS

09:36:40 1 assessment. If we have a critical incident  
09:36:42 2 with us related to a fall, we want to know what  
09:36:44 3 was in place for that resident. Did they have  
09:36:47 4 a call bell in place? Is the resident a  
09:36:50 5 frequent faller? And what was happening at  
09:36:51 6 that time?

09:36:52 7 So if the resident was  
09:36:53 8 experiencing delirium and they had a urinary  
09:36:55 9 tract infection and they were forgetting to use  
09:36:57 10 their call bell and they get up and they have a  
09:37:00 11 fall, what did the home do with that? Did they  
09:37:03 12 update the Plan of Care?

09:37:04 13 So these assessments also  
09:37:06 14 generate what we would call outcome scores. So  
09:37:10 15 if a resident has depression and there is  
09:37:14 16 increase in moods and behaviours, the home has  
09:37:16 17 that opportunity to address that issue. They  
09:37:18 18 can look into doing a different type of  
09:37:20 19 assessment for that resident to identify the  
09:37:23 20 care needs.

09:37:24 21 If a resident is experiencing  
09:37:26 22 pain through the preliminary process, that  
09:37:29 23 again drives the care that the resident needs.  
09:37:32 24 They might need to complete a pain assessment.  
09:37:35 25 They might need to look at the medication that  
09:37:37 26 is being provided to that resident and has it  
09:37:39 27 been effective. They might need to contact the  
09:37:42 28 physician.

09:37:44 29 Q. Okay. You have referred to  
09:37:46 30 the preliminary process. Can you explain that,  
09:37:49 31 what that is?

09:37:51 32 A. So the preliminary process is

09:37:52 1 a screening process. If you think about the  
09:37:55 2 functionality of a resident and the type of  
09:37:58 3 needs they require, so activities of daily  
09:38:01 4 living, a resident who might be able to  
09:38:05 5 participate in part of a transfer but still  
09:38:08 6 requires two staff assistants, this is  
09:38:11 7 information that would be put into the RAI  
09:38:14 8 assessment which would generate any triggers  
09:38:16 9 and then further Care Planned.

09:38:18 10 Q. Okay. And I understand that  
09:38:21 11 RAI/MDS, this is a tool used throughout the  
09:38:25 12 long-term care sector?

09:38:26 13 A. It is. The RAI/MDS  
09:38:28 14 assessment, so if you look at a new admission  
09:38:30 15 of a resident into a home, the home develops a  
09:38:34 16 24-hour Plan of Care. During that time period,  
09:38:37 17 there is an observation of the resident as to  
09:38:40 18 how the resident is functioning in the home.

09:38:42 19 At 14 days, the RAI/MDS  
09:38:45 20 assessment is required to be completed. The  
09:38:47 21 RAI/MDS assessment is completed quarterly, any  
09:38:52 22 significant change in status, and annually.

09:38:57 23 Q. Okay. Does every long-term  
09:38:59 24 care home have a RAI Coordinator?

09:39:01 25 A. All long-term care homes have  
09:39:02 26 a RAI Coordinator, but it could be different in  
09:39:05 27 each home. So a RAI Coordinator could be an RN  
09:39:11 28 or an RPN. Depending on the size of the home,  
09:39:11 29 there could be three RPNs. And it is different  
09:39:14 30 throughout the home as to who completes the  
09:39:16 31 RAI/MDS assessment and who would further  
09:39:19 32 complete the Care Plan and any other ongoing

09:39:21 1 assessments required.

09:39:22 2 Q. So does that mean it is up to

09:39:25 3 the home to determine how they are going to do

09:39:27 4 the RAI/MDS?

09:39:27 5 A. The home determines who will

09:39:29 6 complete the RAI/MDS, but it will be a

09:39:32 7 registered staff member.

09:39:33 8 MS. MINGO: Okay, thank you,

09:39:33 9 those are all my questions.

09:39:35 10 THE COMMISSIONER: Thank you.

09:39:51 11 CROSS-EXAMINATION BY MS.

09:39:51 12 CORRENTE:

09:40:00 13 Q. Good morning, Madam

09:40:01 14 Commissioner. Good morning, Natalie.

09:40:02 15 A. Good morning.

09:40:03 16 Q. I didn't bring my phone with

09:40:07 17 me this time, just in case.

09:40:12 18 Natalie, in your testimony

09:40:14 19 yesterday, you mentioned that Inspectors can

09:40:19 20 voice concerns if they are asked to inspect a

09:40:22 21 home at which they were formerly employed, so

09:40:27 22 if you had concerns about going into a home at

09:40:29 23 which you were formerly employed, you are able

09:40:31 24 to express those concerns?

09:40:32 25 A. Yes, if there was a conflict

09:40:33 26 in the home, you could express those concerns

09:40:35 27 to your manager.

09:40:36 28 Q. And, sorry, you would express

09:40:37 29 those concerns to your manager at the London

09:40:40 30 SAO?

09:40:40 31 A. Yes.

09:40:40 32 Q. And so on the flip side of

09:40:42 1 that, if a licensee had concerns about a former  
09:40:47 2 employee inspecting their home as a Ministry  
09:40:50 3 Inspector, can the licensee raise those types  
09:40:52 4 of concerns?

09:40:53 5 A. I believe the licensee can  
09:40:55 6 contact our SAO Manager and express those  
09:40:58 7 concerns.

09:40:58 8 Q. And if your SAO Manager  
09:41:02 9 didn't agree with the licensee's concerns about  
09:41:06 10 an Inspector who was previously employed at one  
09:41:09 11 of their homes, do you know if there is a  
09:41:11 12 process within the Ministry for the licensee to  
09:41:14 13 challenge the choice of Inspector for a home?

09:41:18 14 A. As an Inspector, I am not  
09:41:20 15 aware.

09:41:20 16 Q. Okay, I have some questions  
09:41:25 17 for you about the nature of the inspection at  
09:41:28 18 Meadow Park London which began in October of  
09:41:31 19 2016.

09:41:32 20 I don't think there is any  
09:41:34 21 dispute that you, or any of the other Ministry  
09:41:37 22 Inspectors, for that matter, had ever inspected  
09:41:40 23 an incident involving the murder of a long-term  
09:41:42 24 care resident by a staff member; is that fair?

09:41:45 25 A. That's correct.

09:41:45 26 Q. And you were appointed as the  
09:41:47 27 lead Inspector at Meadow Park?

09:41:49 28 A. Yes.

09:41:49 29 Q. And you were assisted in your  
09:41:51 30 inspection by Neil Kikuta?

09:41:54 31 A. That's correct.

09:41:55 32 Q. And I understand that



09:41:56 1 Mr. Kikuta was a fairly recent hire to the  
09:42:02 2 Ministry. He began as an Inspector there in  
09:42:02 3 April of 2016?

09:42:02 4 A. I am not sure of the date of  
09:42:04 5 hire, but he was a newer Inspector.

09:42:06 6 Q. Is it fair to say that the  
09:42:10 7 staff at Meadow Park would not have known  
09:42:13 8 Mr. Kikuta very well in October 2016 with him  
09:42:17 9 having worked as a Ministry Inspector for a  
09:42:20 10 short period of time?

09:42:20 11 A. I don't know if I could speak  
09:42:23 12 to if Neil was in the home as an Inspector. I  
09:42:28 13 am not sure if he had previously inspected at  
09:42:30 14 Meadow Park London.

09:42:31 15 Q. Okay, fair enough.

09:42:32 16 And the two of you were tasked  
09:42:36 17 with completing what was a Critical Incident  
09:42:41 18 System inspection of the home relating to the  
09:42:45 19 Elizabeth Wettlaufer offences?

09:42:46 20 A. As well as other critical  
09:42:48 21 incidents and complaints.

09:42:49 22 Q. Right, you brought I believe  
09:42:51 23 you said it was 14 other critical incidents and  
09:42:55 24 complaints with you as part of that larger  
09:42:56 25 inspection?

09:42:57 26 A. Yes.

09:42:57 27 Q. Okay. In paragraph 19 of  
09:43:09 28 your affidavit, and we can turn that up --  
09:43:12 29 sorry, I'm just going to grab my binder,  
09:43:16 30 because I forgot to bring it up.

09:43:18 31 And I just wanted to take you --  
09:43:34 32 oh, are we already there? Great.

09:43:35 1 I wanted to take you to  
09:43:36 2 paragraph 19 on page 6, and I believe you  
09:43:42 3 indicated that before commencing your  
09:43:48 4 inspection, you had been given -- before  
09:43:52 5 commencing the on-site inspection, you had been  
09:43:55 6 given a copy of Elizabeth Wettlaufer's  
09:43:57 7 personnel file?

09:43:58 8 A. So on October 5th was the day  
09:44:01 9 that we had completed that part of the on-site  
09:44:03 10 inspection, and we were given the HR file for  
09:44:05 11 Elizabeth Wettlaufer.

09:44:06 12 Q. And is it fair to say based  
09:44:08 13 on --

09:44:08 14 A. Sorry, I need to correct  
09:44:09 15 myself. That was October 6th, not October 5th.

09:44:12 16 Q. That's right, you did say  
09:44:14 17 October the 6th.

09:44:14 18 Is it fair to say that there was  
09:44:15 19 nothing in the HR file that you reviewed from  
09:44:20 20 Meadow Park London that stood out to you or  
09:44:22 21 that was concerning in respect of Elizabeth  
09:44:25 22 Wettlaufer?

09:44:25 23 A. In respect of Elizabeth  
09:44:28 24 Wettlaufer, no. In respect to the reference  
09:44:31 25 letter, yes.

09:44:32 26 Q. Okay, but we are talking  
09:44:36 27 about and my question to you was just about the  
09:44:39 28 HR file that had been created by Meadow Park.  
09:44:41 29 I wasn't referring to Caressant Care.

09:44:42 30 A. Yes.

09:44:43 31 Q. Okay. And on page 20 of your  
09:44:48 32 affidavit, you also state that you reviewed

09:44:50 1 Meadow Park London's compliance history prior  
09:44:53 2 to starting your inspection, and that, again,  
09:44:56 3 nothing stood out to you regarding any previous  
09:44:59 4 compliance history relating to Elizabeth  
09:45:01 5 Wettlaufer?

09:45:01 6 A. That's correct.

09:45:02 7 Q. So turning now to the  
09:45:11 8 inspection process itself at Meadow Park, so  
09:45:17 9 you began the inspection on October the 6th,  
09:45:19 10 2016?

09:45:20 11 A. Yes.

09:45:21 12 Q. And that portion of it was  
09:45:24 13 when you and Ms. Kukoly first attended at the  
09:45:28 14 home and you spoke to the Administrator?

09:45:29 15 A. Yes.

09:45:29 16 Q. And I take it that, like  
09:45:32 17 other inspections, your attendance was not  
09:45:34 18 announced that day; you went unannounced?

09:45:37 19 A. We were unannounced.

09:45:39 20 Q. But nevertheless, the  
09:45:40 21 Administrator, Nicole Ross, had anticipated  
09:45:43 22 your visit and she had ready for you a copy of  
09:45:45 23 the personnel file for Ms. Wettlaufer and the  
09:45:48 24 entire record for Mr. Horvath?

09:45:49 25 A. My understanding at that time  
09:45:51 26 was that Nicole Ross had a conversation with  
09:45:54 27 Karen Simpson, the Director, prior to us coming  
09:45:57 28 to the home.

09:45:57 29 Q. So she would have known that  
09:45:59 30 you were coming?

09:45:59 31 A. That we were requesting  
09:46:01 32 certain documents and we would be coming to the

09:46:02 1 home.

09:46:03 2 Q. Okay. And I further  
09:46:06 3 understand that you and Neil Kikuta had been  
09:46:11 4 directed by Peggy Skipper not to speak to  
09:46:16 5 anyone else at the home on that -- sorry, back  
09:46:18 6 up.

09:46:19 7 And I understand that you and it  
09:46:21 8 was Ms. Kukoly that had been directed by your  
09:46:24 9 Manager, Peggy Skipper, not to speak to anyone  
09:46:26 10 else at the home that day given the ongoing  
09:46:29 11 police investigation?

09:46:30 12 A. The direction came from the  
09:46:31 13 Director, Karen Simpson.

09:46:32 14 Q. Okay, but I am right that you  
09:46:34 15 were directed to only speak to the  
09:46:35 16 Administrator and not anyone else?

09:46:36 17 A. That's correct.

09:46:37 18 Q. Okay. And that was unusual  
09:46:38 19 for you as an Inspector, wasn't it, to be  
09:46:42 20 restricted to speaking only to the  
09:46:45 21 Administrator at the home and not anyone else?

09:46:46 22 A. Yes.

09:46:46 23 Q. And you testified yesterday  
09:46:52 24 that initially, given this direction, you were  
09:46:55 25 getting information from staff through the  
09:46:59 26 Administrator because there was still this  
09:47:01 27 ongoing police investigation and you didn't  
09:47:03 28 want to interfere with it?

09:47:04 29 A. That's correct.

09:47:05 30 Q. So is it fair to say that  
09:47:08 31 from the outset of this inspection, both for  
09:47:12 32 you and the staff at Meadow Park, this was not

09:47:14 1 the type of inspection to which you both were  
09:47:17 2 accustomed?

09:47:18 3 A. This was an -- it was unusual  
09:47:20 4 to not be able to speak to the staff when we  
09:47:23 5 entered a home.

09:47:23 6 Q. Okay, but I am suggesting  
09:47:27 7 more than that. So Ms. Kukoly testified the  
09:47:30 8 other day that, you know, her words were  
09:47:33 9 everything new, everything was new about this  
09:47:35 10 inspection process.

09:47:35 11 And I am asking you if it is  
09:47:37 12 fair to say that there were definitely new  
09:47:39 13 aspects about this process that would have been  
09:47:42 14 new to you and unfamiliar to the staff at  
09:47:45 15 Meadow Park?

09:47:45 16 A. They were unusual and they  
09:47:48 17 would have been new to the staff that we  
09:47:51 18 couldn't approach them to interview them.

09:47:54 19 Q. Okay.

09:47:55 20 A. The observation and record  
09:47:58 21 reviews would have been the same.

09:47:59 22 Q. Okay. It was also, and we'll  
09:48:00 23 get into this a bit further, but it was also  
09:48:03 24 new to the staff to be audio recorded during  
09:48:06 25 their interviews?

09:48:06 26 A. Correct.

09:48:07 27 Q. And it would have also been  
09:48:10 28 new to the staff that while you weren't  
09:48:13 29 speaking to them, you were still making  
09:48:15 30 observations around the home?

09:48:17 31 A. In a critical incident, yes.  
09:48:23 32 Not necessarily in an RQI.

09:48:25 1 Q. Okay. But it was a critical  
09:48:27 2 incident --

09:48:27 3 A. Correct.

09:48:28 4 Q. -- inspection?

09:48:29 5 A. Yes.

09:48:29 6 Q. Okay. So after October the  
09:48:31 7 6th, the next time that you attended at the  
09:48:34 8 home was on October the 28th; is that right?

09:48:36 9 A. Yes.

09:48:37 10 Q. Okay. And if we can pull up  
09:48:41 11 from your affidavit Exhibit "C", which is  
09:48:46 12 document 40987, and if we can go to page 1.

09:48:57 13 Just scroll down a little. Keep  
09:49:03 14 going. Just a little more. Yeah, right there.

09:49:06 15 So listed under "The purpose of  
09:49:12 16 this inspection was to conduct a Critical  
09:49:14 17 Incident System inspection" are the dates, are  
09:49:16 18 several dates. Am I correct that those are the  
09:49:18 19 dates that you would have been in the home?

09:49:19 20 A. Yes, myself or Neil would  
09:49:21 21 have been in the home.

09:49:21 22 Q. Okay. And by my count, there  
09:49:28 23 are 47 separate dates, including October the  
09:49:31 24 6th, so there would be 46 listed there plus  
09:49:34 25 October the 6th, at which Inspectors were in  
09:49:38 26 the home?

09:49:39 27 A. I haven't counted the dates,  
09:49:40 28 but I will go by those numbers.

09:49:42 29 Q. Okay. And based on these  
09:49:48 30 dates, it appears that the Ministry inspection  
09:49:51 31 lasted from early October 2016 to late February  
09:49:56 32 2017, so approximately five months?

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A. Correct.

Q. And is it fair to say that that would have been the most lengthy Ministry inspection that either you or the home had ever experienced?

A. For myself, being that I was hired from 2014, and then I would assume for the home.

Q. So for both of you, yes? I'm right about that?

A. Yes.

Q. And you were not the only Inspectors in the home during these months, that is, the London Police Service was conducting at the same time its criminal investigation into Elizabeth Wettlaufer?

A. Yes.

Q. And there -- and the police would have been interviewing staff members as well and collecting documents?

A. My understanding from Karen Simpson is that is what they were doing.

Q. And there were many days when both you and the Ministry -- sorry, there were many days when both police and you as the Ministry Inspectors were in the home at the same time gathering documents and interviewing witnesses?

A. I can recall one time where they were in at the same time we were in.

Q. Okay, your recollection is just one time?

09:51:00 1 A. Just the one time.

09:51:01 2 Q. But there were days that you

09:51:02 3 said that Neil was there and you weren't?

09:51:03 4 A. That's correct.

09:51:04 5 Q. Okay. And Karen Simpson

09:51:10 6 testified the other day that she didn't want to

09:51:13 7 miss anything in relation to the inspections

09:51:16 8 conducted at the facilities, so you know --

09:51:20 9 and do you recall that testimony?

09:51:21 10 A. I recall her testimony, but I

09:51:24 11 don't recall that verbatim.

09:51:25 12 Q. Okay. Is it fair to say, you

09:51:29 13 know, in your view, do you feel that you

09:51:31 14 completed a thorough and comprehensive

09:51:34 15 inspection at Meadow Park London from October

09:51:36 16 to February 2017?

09:51:37 17 A. Yes, I do, in regards to

09:51:43 18 Elizabeth Wettlaufer.

09:51:44 19 Q. And in regards to the 14

09:51:47 20 other complaints and critical incidents that

09:51:49 21 you inspected; is that fair?

09:51:50 22 A. Yes.

09:51:51 23 Q. I think it is important for

09:51:55 24 the public and for the Commissioner to

09:51:56 25 understand just, you know, the level of

09:51:58 26 scrutiny that was applied to your inspection,

09:52:02 27 so I want to go through that a bit.

09:52:03 28 And maybe we can turn, we are

09:52:05 29 still at Exhibit "C", if we can go to the next

09:52:08 30 page, yes, where it starts "During the [...]"

09:52:17 31 the inspection [...]"

09:52:21 32 I want to go to that second



09:52:23 1 paragraph, and please take a read of it, and  
09:52:26 2 then I'm going to ask you some questions about  
09:52:27 3 it, the paragraph that begins "During the  
09:52:31 4 months of October, November and December [...]"

09:52:31 5 A. [Witness reviews document.]

09:52:40 6 Q. Okay, so for based on what  
09:52:44 7 you have written in this Inspection Report, I  
09:52:45 8 gather that for the purposes of your  
09:52:47 9 inspection, you made observations of resident  
09:52:49 10 care?

09:52:49 11 A. Yes, we did.

09:52:50 12 Q. And you observed the  
09:52:52 13 medication rooms and the medication carts?

09:52:54 14 A. That's correct.

09:52:55 15 Q. And you observed medication  
09:52:58 16 administration?

09:52:58 17 A. Yes.

09:52:59 18 Q. And that would have included  
09:53:01 19 in fact watching nursing staff complete part of  
09:53:04 20 a medication pass?

09:53:05 21 A. That's correct.

09:53:05 22 Q. And you also observed drug  
09:53:09 23 destruction of both controlled and  
09:53:11 24 non-controlled substances?

09:53:12 25 A. Yes.

09:53:13 26 Q. Okay. And I understand that  
09:53:17 27 you also took photographs of a number of things  
09:53:19 28 in the home?

09:53:20 29 A. Yes, Neil Kikuta took  
09:53:23 30 photographs of issues in the home related to  
09:53:25 31 the medication.

09:53:26 32 Q. Sorry, did you say Neil?

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A. Neil.

Q. You would have also reviewed a number of documents as part of your inspection; is that true?

A. Yes.

Q. Okay, so resident records were reviewed?

A. Resident health care records, yes.

Q. And documentation relating to ordering and receiving medication from pharmacy?

A. Yes.

Q. Documentation for medication administration on the eMAR?

A. Correct.

Q. Documentation relating to signage of controlled substances?

A. Yes.

Q. Numerous written policies and procedures of the home, as well as from the pharmacy service provider?

A. Yes.

Q. And there were other -- there was other relevant documents as well, documentation as well?

A. Correct.

Q. And I understand that you also had access through your own computers to the home's Point Click Care system through which you are able to access plans of care; is that true?

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A. Yes.

Q. So you would agree with me that you had gathered an extensive amount of documentation from the home for the purposes of your inspection?

A. Yes.

Q. Okay. And I also see from this Inspection Report that you interviewed a number of people. And I'm sorry, I don't have a copy of the exhibit that we just introduced today.

MS. STEPHENS: I don't have an extra one, I'm sorry.

MS. CORRENTE: Okay.

MS. STEPHENS: You could pull it up.

MS. CORRENTE: Okay, we can pull it up, and the exhibit number for that I don't have either.

THE COMMISSIONER: 143.

MS. CORRENTE: I think it was 143 as an exhibit number, but I don't have the document number, my apologies.

THE COURT CLERK: So that is 41196.

THE COMMISSIONER: Thank you.

BY MS. CORRENTE:

Q. Okay, so have you had a chance to run through this list?

A. Yes, I have.

Q. Okay. And so on this list,

09:55:27 1 you would have spoken to the Chief Operating  
09:55:29 2 Officer for Jarlette? And I will just run  
09:55:35 3 through the list just to confirm that you had  
09:55:37 4 spoken to these people.

09:55:38 5 A. Okay.

09:55:38 6 Q. You know what, if it is  
09:55:40 7 easier for you, we can go back to the  
09:55:42 8 Inspection Report for a second, because I think  
09:55:44 9 this might make it easier.

09:55:46 10 So if we can go back to document  
09:55:52 11 40987, back to page 2, okay, and the first  
09:56:08 12 paragraph, so just scroll a little higher.

09:56:12 13 Okay, and in that paragraph that  
09:56:15 14 begins after "Critical Incident Log", and it  
09:56:18 15 starts "During the course of the inspection  
09:56:20 16 [...]", it lists a number of people?

09:56:23 17 A. Correct.

09:56:23 18 Q. And take a minute to review  
09:56:24 19 that, if you need to.

09:56:25 20 A. [Witness reviews document.]

09:56:35 21 Okay.

09:56:36 22 Q. Okay, and so this group here  
09:56:38 23 would have included both current and former  
09:56:42 24 staff members of Meadow Park London?

09:56:43 25 A. Yes.

09:56:43 26 Q. And it would have included  
09:56:45 27 members from its corporate head office?

09:56:47 28 A. Yes.

09:56:48 29 Q. Members of senior management  
09:56:49 30 at the home?

09:56:50 31 A. Yes.

09:56:50 32 Q. Nursing staff?

09:56:51 1 A. Yes.

09:56:52 2 Q. Physicians?

09:56:53 3 A. No.

09:56:54 4 Q. I thought --

09:56:55 5 A. I don't recall if I talked to

09:56:58 6 physicians --

09:56:58 7 Q. It says here physicians.

09:56:59 8 A. Oh, sorry, yes, two

09:57:00 9 physicians.

09:57:00 10 Q. Yeah, so physicians as well?

09:57:02 11 A. Yes.

09:57:02 12 Q. The Pharmacy Consultant?

09:57:03 13 A. Yes.

09:57:04 14 Q. Okay. So by my count, there

09:57:08 15 are, and I am just talking about staff, on this

09:57:12 16 list it appears about 51 current and former

09:57:15 17 staff members at Meadow Park which you would

09:57:18 18 have interviewed; is that a fairly accurate

09:57:20 19 estimate? And if you need the Exhibit 143 to

09:57:27 20 confirm that, please feel free.

09:57:28 21 A. That's okay. Yes.

09:57:29 22 Q. Okay. And in addition to

09:57:33 23 these 51 current and former staff members, you

09:57:36 24 also interviewed families?

09:57:41 25 A. One family.

09:57:41 26 Q. One family, okay, and you

09:57:43 27 also interviewed residents?

09:57:44 28 A. That's correct.

09:57:44 29 Q. Okay, and any sense of how

09:57:46 30 many residents you would have interviewed?

09:57:47 31 A. I would need to see the

09:57:49 32 resident list.

09:57:49 1 Q. Okay. More than one?

09:57:51 2 A. Yes.

09:57:51 3 Q. Okay. Any estimate at all?

09:57:56 4 A. I would be guessing.

09:57:57 5 Q. Okay, fair enough.

09:57:59 6 So and you would also agree with

09:58:02 7 me that some of the staff members -- and when I

09:58:05 8 use "staff members" going forward, I am going

09:58:07 9 to suggest to you that I mean both current and

09:58:09 10 former staff members.

09:58:10 11 A. Yes.

09:58:10 12 Q. Some of the staff members you

09:58:13 13 interviewed more than once?

09:58:14 14 A. Yes.

09:58:14 15 Q. And my recollection is that

09:58:19 16 the interviews of staff took place in a spare

09:58:23 17 office at the home?

09:58:24 18 A. Correct.

09:58:25 19 Q. And the staff were

09:58:28 20 interviewed by both you and Mr. Kikuta. You

09:58:31 21 asked the questions, and he typed, presumably,

09:58:34 22 the questions and the answers on to his

09:58:36 23 computer?

09:58:37 24 A. Yes.

09:58:37 25 Q. And these staff interviews

09:58:41 26 were also audio recorded?

09:58:43 27 A. Correct.

09:58:43 28 Q. And this was the first time

09:58:45 29 that you as Ministry Inspectors had ever audio

09:58:49 30 recorded interviews at Meadow Park London?

09:58:51 31 A. Yes.

09:58:52 32 Q. Now, Ms. Kukoly in her

09:58:57 1 affidavit mentioned training by a police  
09:58:59 2 officer in relation to other things, including  
09:59:02 3 audio recording.  
09:59:04 4 Did you -- had you ever received  
09:59:06 5 any training on audio recording prior to  
09:59:08 6 conducting these interviews?  
09:59:09 7 A. Yes, at the same time as  
09:59:12 8 Rhonda did.  
09:59:13 9 Q. Okay, and do you know when  
09:59:15 10 that was?  
09:59:15 11 A. I don't recall.  
09:59:15 12 Q. And what were you -- in that  
09:59:19 13 training, what were you taught in terms of  
09:59:21 14 audio recordings?  
09:59:22 15 A. I don't recall.  
09:59:25 16 Q. Did you recall what you were  
09:59:28 17 taught at the time that you were conducting  
09:59:30 18 these interviews? Would you know that?  
09:59:33 19 A. We had a policy as well as  
09:59:35 20 direction as to the type of questions that we  
09:59:38 21 would be asking and the direction on how we  
09:59:42 22 would propose those questions.  
09:59:43 23 Q. Okay. Did you ever give any  
09:59:48 24 guidance or direction to the staff about the  
09:59:50 25 audio recording that was going to take place?  
09:59:53 26 Did you ever explain anything in relation to  
09:59:55 27 that?  
09:59:55 28 A. I believe we did for each  
09:59:56 29 staff. We did tell them that we would be audio  
09:59:58 30 recording them, that we told them that at any  
10:00:01 31 time that they needed to take a break they  
10:00:05 32 could, if they had felt uncomfortable. If they

1 didn't know an answer, they could always come  
2 back and tell us.

3 Q. Okay. So while the Ministry  
4 Inspectors were able to audio record the  
5 interviews, staff were not permitted to audio  
6 record?

7 A. Staff were not permitted to  
8 audio record.

9 And I just want to take a step  
10 back, because in 2014 the audio recordings only  
11 related to the incidents in 2014 regarding  
12 Elizabeth Wettlaufer. The 2016 inspections  
13 that were being concurrently investigated were  
14 not audio recorded.

15 And in 2014, the staff members  
16 at that time during the audio recording had  
17 legal representation.

18 Q. Okay. But back to my  
19 question, the staff members, whether -- when  
20 they were being audio recorded for whatever  
21 purpose were not also allowed to audio record  
22 the interviews; it was only the Ministry who  
23 could record?

24 A. Correct.

25 Q. Okay. Natalie, would you  
26 agree with Karen Simpson's statement that she  
27 made during her testimony that the inspection  
28 process can be stressful and intimidating for  
29 staff?

30 A. I don't recall Karen saying  
31 that.

32 Q. Okay, well, in your view, can



10:01:34 1 the -- can an inspection process be stressful  
10:01:36 2 and intimidating for staff?

10:01:38 3 A. I would hope not. We do  
10:01:41 4 explain to them that we are there to gather  
10:01:43 5 information, that we are not there to  
10:01:46 6 discipline them, that we are inspecting -- we  
10:01:48 7 explain to them exactly what we'll be  
10:01:50 8 inspecting upon, so if it was a Critical  
10:01:54 9 Incident Report related to a fall, we were  
10:01:55 10 going to ask questions related to a fall.

10:01:57 11 If they felt uncomfortable at  
10:01:59 12 any time, we could stop the interview,  
10:02:03 13 interview someone else, or do the interview at  
10:02:05 14 a later date.

10:02:06 15 Q. Okay, but in this particular  
10:02:07 16 circumstance, you weren't inspecting a critical  
10:02:11 17 incident in relation to a fall. You were  
10:02:12 18 inspecting the offences, the murder committed  
10:02:16 19 by Elizabeth Wettlaufer at a time when the  
10:02:21 20 homes were or the staff at the homes were -- or  
10:02:25 21 you know, had recently learned about what had  
10:02:27 22 happened.

10:02:27 23 And so you would agree with me  
10:02:29 24 that this was a stressful and overwhelming  
10:02:35 25 process, not just for you as Inspectors but for  
10:02:39 26 the staff at the home as well?

10:02:40 27 A. I would say that, yes.

10:02:42 28 Q. Do you recall some staff  
10:02:48 29 members, at least one staff member requesting  
10:02:51 30 to have a support person present with them  
10:02:53 31 during the interview?

10:02:54 32 A. I don't recall.

1 Q. You don't recall Nicole Ross,  
2 the Administrator, requesting to have the Care  
3 Service Coordinator present during her  
4 interview?

5 A. I don't recall.

6 Q. It is possible that that may  
7 have happened, however?

8 A. It could be possible.

9 Q. Okay. And do you recall that  
10 none of the people that you had interviewed had  
11 a support person with them in the room?

12 A. This would not be abnormal.  
13 When we interview staff, we do interview them  
14 by themselves.

15 Q. Okay, and that is a fair  
16 answer, but my question to you was in this  
17 particular -- with respect to these particular  
18 interviews and this particular inspection,  
19 there was no support person offered or present  
20 for the interviews of staff?

21 A. And as for our process, there  
22 wouldn't be.

23 Q. Okay. And were you at the  
24 time familiar with the Long-Term Care Homes  
25 Act? And we can bring up the legislation at --  
26 it is number 5, FD0005, page 899. It is under  
27 section 147, I believe. Okay, I lost it. You  
28 had it and I lost it. 147, keep going down.  
29 It is (d), yeah, (d).

30 So were you familiar with  
31 section 147(1)(d) at the time which was in  
32 place that said:

10:05:03 1 "An Inspector conducting an  
10:05:04 2 inspection,  
10:05:06 3 May question a person,  
10:05:09 4 subject to the person [...]  
10:05:11 5 having counsel present during  
10:05:12 6 the [inspection]"?  
10:05:14 7 A. I became aware of that during  
10:05:16 8 the inspection.  
10:05:18 9 Q. Okay. And given your  
10:05:20 10 testimony that it would have been abnormal to  
10:05:24 11 have a support person there given that these  
10:05:27 12 interviews were conducted I'll say, you know,  
10:05:29 13 two-on-one, two Inspectors with the  
10:05:32 14 interviewee, was it your interpretation then  
10:05:34 15 that a person was not entitled to have a  
10:05:40 16 support person present, subject only to their  
10:05:43 17 right to have counsel? Was that your  
10:05:52 18 interpretation?  
10:05:52 19 A. When I read that  
10:05:54 20 interpretation, it says:  
10:05:55 21 "[...] subject to the person's  
10:05:57 22 right to have counsel present  
10:05:58 23 during the questioning."  
10:05:59 24 Not "a person".  
10:06:00 25 Q. So you are not interpreting  
10:06:02 26 "counsel" to mean a support person?  
10:06:04 27 A. No, I am not.  
10:06:05 28 Q. And how was it that you would  
10:06:06 29 have interpreted "counsel" ?  
10:06:07 30 A. I would "counsel" as a legal  
10:06:09 31 representation.  
10:06:09 32 Q. So a lawyer?

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10:07:14 26  
10:07:15 27  
10:07:18 28  
10:07:20 29  
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10:07:24 31  
10:07:25 32

A. Yes.

Q. And it is fair to say that since staff were not permitted to bring in what we will call a support person into the interview, that some of the staff opted to bring in legal counsel for support?

A. The staff did have legal representation.

Q. Some of the staff?

A. Some of the staff.

Q. And they opted to bring in that legal representation because they weren't able to have a support person present?

A. That is not my understanding. I was approached by Nicole Ross in the home, who was the Administrator at that time, and I was told that they would be having legal representation for any of the concerns related to 2014 with relation to Elizabeth Wettlaufer.

Q. And I am suggesting to you that the reason why Nicole Ross took that approach was because she requested to have a support person in the form of Christina Bath, and that was denied by the Ministry Inspectors?

A. I would not be aware of that. Nicole didn't voice that to me.

Q. You would agree with me that legal counsel was not present for the interview of every staff member, were they?

A. There were staff members that did not want legal counsel.

Q. And the staff members

10:07:28 1 actually expressed that to you, that they  
10:07:31 2 didn't want legal counsel, or there was just no  
10:07:33 3 legal counsel present?

10:07:34 4 A. The one staff member that I  
10:07:35 5 do recall had said that they did not want legal  
10:07:38 6 counsel from Jarlette.

10:07:38 7 Q. That was one staff member?

10:07:39 8 A. Yes.

10:07:40 9 Q. But the other staff members  
10:07:42 10 didn't express that one way or another?

10:07:43 11 A. I don't recall any other  
10:07:44 12 staff member expressing that.

10:07:45 13 Q. Right, so there were staff  
10:07:46 14 members who opted not to have legal counsel  
10:07:48 15 present, and there were some staff members who  
10:07:51 16 opted to have legal counsel present?

10:07:52 17 A. The only one person that I  
10:07:56 18 can recall that did not want legal counsel  
10:07:58 19 present -- present during the inspection.

10:08:02 20 Q. Okay, I don't know if we are  
10:08:05 21 saying the same thing and maybe in just  
10:08:09 22 different ways, so I'll rephrase my question.

10:08:11 23 There were about 51 staff  
10:08:13 24 members that were interviewed by you, you had  
10:08:15 25 said?

10:08:16 26 A. Approximately, yes.

10:08:16 27 Q. And not all of those staff  
10:08:19 28 members had legal counsel present?

10:08:22 29 A. For the inspection in 2014.  
10:08:24 30 This is, just to clarify, we are just  
10:08:26 31 discussing 2014, not 2016 inspections that were  
10:08:31 32 concurrently being -- taking place in the home.

1 Q. Okay, but I don't know how  
2 these inspections may have been separated, but  
3 I believe you had said for that for the 2016  
4 portion, none of them had legal counsel  
5 present; is that true?

6 A. That's correct.

7 Q. Okay. So you know, for the  
8 purposes of matters that related to EW, again,  
9 not all of the staff members had legal counsel  
10 present?

11 A. I recall one staff member not  
12 having legal counsel present by their choice.

13 Q. By their?

14 A. By their choice.

15 Q. Okay, but that is not what I  
16 am asking you. Other than that one staff  
17 member who didn't have legal counsel, there  
18 were various other staff members who also did  
19 not have legal counsel?

20 A. No, I don't recall that.

21 Q. Your recollection is that  
22 legal counsel was present for 50 of those 51  
23 staff interviews?

24 A. For the staff interviews, I  
25 only recall one staff member that did not have  
26 legal counsel, and that was their choice.

27 Q. I am suggesting to you that  
28 less than half of the staff members that you  
29 interviewed had legal counsel present.

30 A. I don't recall that.

31 Q. But it is certainly possible?

32 A. I would need to be able to

1 review our interviews during that time at  
2 Meadow Park London.

3 Q. Well, I think that this is an  
4 important point and --

5 MS. MINGO: I'm sorry, the  
6 witness has answered this  
7 question already.

8 MS. CORRENTE: Well, her answer  
9 is that she doesn't recall, and  
10 I suggest that her interview  
11 notes are going to suggest  
12 otherwise. And if she needs an  
13 opportunity to get that  
14 clarification, she should get  
15 it.

16 MS. MINGO: Are you suggesting  
17 we go to her interview notes, or  
18 are you just going to ask her  
19 again?

20 BY MS. CORRENTE:

21 Q. No, well, I have asked her  
22 the question. She says she doesn't remember.

23 Is there somewhere that you can  
24 look to refresh your memory?

25 A. The interviews are within the  
26 Medication IP.

27 Q. And they would indicate  
28 whether or not legal counsel is present?

29 A. It would.

30 MS. CORRENTE: Okay, so I am in  
31 your hands, Madam Commissioner.

32 THE COMMISSIONER: I don't have

10:10:28 1 a problem with you having the --  
10:10:31 2 directing the witness to look at  
10:10:32 3 what she can.  
10:10:33 4 MS. CORRENTE: Now, the  
10:10:33 5 Medication IP, from what I  
10:10:35 6 recall, is about a 200-page  
10:10:37 7 document that has a lot of text  
10:10:38 8 in it, so it is not going to be  
10:10:40 9 easy for me to find all of those  
10:10:43 10 references on the spot.

10:10:45 11 So if we need about 15  
10:10:48 12 minutes for her to locate them  
10:10:50 13 and satisfy herself, I am happy  
10:10:51 14 to give her that time.

10:10:53 15 THE COMMISSIONER: I am too.  
10:10:53 16 And it will also give you an  
10:10:55 17 opportunity to discuss whether  
10:10:57 18 or not you are going to maintain  
10:10:58 19 an objection on that point. I  
10:11:00 20 don't hear you objecting to  
10:11:01 21 that.

10:11:02 22 MS. MINGO: I don't object to  
10:11:03 23 going to the notes, if that is  
10:11:04 24 where my friend wants to go.  
10:11:06 25 Just asking the question over  
10:11:07 26 and over again doesn't seem like  
10:11:09 27 it is going to produce a  
10:11:10 28 different answer.

10:11:10 29 THE COMMISSIONER: All right, I  
10:11:11 30 have to say, I didn't see it as  
10:11:13 31 badgering the witness. I saw it  
10:11:14 32 as trying to clarify a point.



10:11:17 1 There was clearly a difference  
10:11:18 2 there.  
10:11:18 3 But I would suggest that if  
10:11:19 4 this is an important issue, then  
10:11:21 5 we should recess until 10:30,  
10:11:23 6 give this witness an opportunity  
10:11:25 7 to review her notes, give you an  
10:11:28 8 opportunity to review them as  
10:11:29 9 well, and hopefully that time  
10:11:30 10 will allow us to deal with this  
10:11:32 11 matter in relatively short  
10:11:36 12 compass.  
10:11:36 13 MS. CORRENTE: Okay, thank you.  
10:11:36 14 -- RECESSED AT 10:11 A.M.  
10:33:59 15 -- RESUMED AT 10:33 A.M.  
10:33:59 16 MS. CORRENTE: Thank you, Madam  
10:34:02 17 Commissioner, for that somewhat  
10:34:03 18 brief indulgence. I think that  
10:34:08 19 we are going to be able to deal  
10:34:09 20 with this in a more streamlined  
10:34:11 21 way, rather than having to go  
10:34:13 22 back to lots of documents.  
10:34:13 23 BY MS. CORRENTE:  
10:34:14 24 Q. So, Natalie, I just wanted to  
10:34:16 25 clarify something that came up during the  
10:34:19 26 break.  
10:34:20 27 Exhibit 143, just so we are  
10:34:23 28 clear, you had testified earlier that this was  
10:34:26 29 a list of people that were interviewed; is  
10:34:30 30 that --  
10:34:30 31 A. That is --  
10:34:32 32 Q. That is correct?

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A. Yes.

Q. But that is not actually the case?

A. In the staff interview list, there are staff members that might not have been interviewed but were referenced in our report or within our IPs.

Q. Okay. So it is fair to say then that this Staff Inventory List includes people that were interviewed and also includes others that were referenced in the Inspection Report but who were not interviewed?

A. Right, as well as the IPs.

Q. Okay.

THE COMMISSIONER: As well as what?

THE WITNESS: As well as the IPs, the Inspection Protocols.

BY MS. CORRENTE:

Q. Okay. And you know, an obvious example of this is that Elizabeth Wettlaufer is listed on this Staff Inventory List, and certainly she was not a person who was part of the interview process?

A. That's correct.

Q. Okay. And you know, if we needed to, we could go to the audiotapes of each witness to confirm whether or not legal counsel was present, because the audiotapes would indicate that; is that fair to say?

A. Yes.

Q. Okay. So rather than go

10:35:30 1 through that exercise, in the interests of  
10:35:33 2 time, I am going to suggest to you a few things  
10:35:37 3 and you can tell me whether or not you agree.

10:35:39 4 We had -- I think we have  
10:35:42 5 already established that you are comfortable  
10:35:44 6 somewhat with the number of 51 staff members  
10:35:48 7 having been interviewed as part of your  
10:35:51 8 inspection?

10:35:51 9 A. Correct.

10:35:52 10 Q. And is it fair to say then  
10:35:55 11 that those staff members to whom you spoke only  
10:36:00 12 about matters in 2016 unrelated to EW were not  
10:36:07 13 represented by legal counsel?

10:36:09 14 A. Correct.

10:36:10 15 Q. And is it also fair to say  
10:36:12 16 that from the group of individuals that were  
10:36:15 17 interviewed, the representatives from  
10:36:18 18 Jarlette's corporate head office also did not  
10:36:21 19 have legal counsel?

10:36:22 20 A. Correct.

10:36:23 21 Q. And is it also fair to say  
10:36:26 22 that the physicians, the two physicians that  
10:36:32 23 were interviewed did not have legal counsel?

10:36:34 24 A. Correct.

10:36:36 25 Q. And is it also fair to say  
10:36:39 26 that with the exception of Jonathan Lu, who was  
10:36:45 27 the pharmacist from Silver Fox, the other  
10:36:49 28 pharmacists who were interviewed from Classic  
10:36:53 29 Care also did not have legal representation?

10:36:56 30 A. Yes.

10:36:58 31 Q. And I suggest to you that  
10:37:02 32 there were also frontline staff, the RNs, the

10:37:07 1 RPNs, the PSWs, whom you interviewed and some  
10:37:16 2 of them did not have legal counsel?

10:37:17 3 A. Related to the 2016  
10:37:18 4 inspections.

10:37:19 5 Q. Okay, that is your  
10:37:20 6 recollection of things?

10:37:20 7 A. Yes.

10:37:21 8 Q. Okay. So when we are talking  
10:37:29 9 about the frontline staff, you are aware that  
10:37:32 10 these frontline staff are unionized staff?

10:37:35 11 A. Yes, I am.

10:37:36 12 Q. And you are aware that as  
10:37:38 13 unionized staff, and I appreciate that your  
10:37:41 14 inspections are not disciplinary meetings, but  
10:37:44 15 you are aware that frontline staff who are  
10:37:46 16 unionized are typically accustomed to having a  
10:37:49 17 support person in the form of a union rep  
10:37:51 18 present at meetings?

10:37:52 19 A. Yes.

10:37:55 20 Q. And I may have asked you this  
10:38:02 21 question already, and if I did, I apologize.  
10:38:04 22 Were you aware that the police also allowed the  
10:38:08 23 staff when being interviewed in relation to EW  
10:38:10 24 to have a support person present? Were you  
10:38:12 25 aware of that?

10:38:15 26 A. No, I was not.

10:38:16 27 Q. And you have noticed that in  
10:38:18 28 these Inquiry proceedings, many of the  
10:38:19 29 witnesses, including those from the Ministry,  
10:38:21 30 have come here with support persons, spouses,  
10:38:25 31 colleagues, friends; have you noticed that?

10:38:27 32 A. Yes.

1 Q. And so I take it that you can  
2 appreciate why in these stressful and  
3 overwhelming circumstances some of the staff at  
4 Meadow Park London would want a support person  
5 there during your inspection? You can  
6 appreciate why they may have wanted that?

7 A. Wanted legal counsel present?

8 Q. A support person is what I  
9 asked you.

10 A. I'm not a -- for me to say  
11 yes to that, I didn't have staff come to me and  
12 tell me that they wanted a support person there  
13 with them.

14 Q. You can understand why then  
15 they would have brought legal counsel with them  
16 if that was the only support person they could  
17 bring?

18 A. I could understand that.

19 Q. Thank you. Okay, so now if  
20 we can turn to some of the findings that you  
21 made as a result of your inspection, you  
22 testified that you reviewed the entire  
23 Medication IP for the purposes of your  
24 inspection, and that was the first time that  
25 that ever happened at a home, to review the  
26 entire Medication IP?

27 A. Yes, that is my  
28 understanding.

29 Q. Okay. And can we bring up  
30 document number 47625. And I apologize, if  
31 there was an exhibit number attached to it, I  
32 don't have it, but it is 47625. I know we have

1 referenced it before in these proceedings.

2 Are you okay looking at it on  
3 the screen?

4 A. Yes, that's okay.

5 Q. Okay, so was this the  
6 Medication IP that you applied for the purposes  
7 of your inspection?

8 A. That looks like the  
9 Medication IP.

10 Q. It does? Do you want -- we  
11 can scroll through it.

12 A. The "Inspection Protocol" it  
13 says on the top, so yes.

14 Q. Yeah, I just want to be sure  
15 it is -- you applied the current Medication IP  
16 to your inspection?

17 A. Yes, I believe it is the same  
18 Medication IP now, yes.

19 Q. Okay. And now if I can take  
20 you to Exhibit "B" of your affidavit, which is  
21 40984, and there that is the Compliance Order  
22 that you issued in relation to your inspection?

23 A. Yes.

24 Q. And Ms. Stephens yesterday  
25 took you through some of your findings on page  
26 4. Now, are these ten -- on pages 4 and 5, are  
27 these the ten findings of non-compliance that  
28 you made in relation to the medication  
29 management system?

30 A. Yes, these are the grounds.

31 Q. Okay. And when it says  
32 various section numbers like section 114,

10:41:36 1 section 122, those are references to  
10:41:39 2 non-compliance with specific portions of the  
10:41:41 3 regulation under the Act?

10:41:43 4 A. Yes, within the Medication  
10:41:45 5 IP.

10:41:45 6 Q. Right, but those are specific  
10:41:46 7 sections in the regulation?

10:41:48 8 A. Yes.

10:41:48 9 Q. Okay. And so based on this  
10:41:54 10 Compliance Order, it was your view that with  
10:41:58 11 respect to the medication management system,  
10:42:00 12 there were ten sections of the regulation that  
10:42:04 13 had not been complied with?

10:42:05 14 A. Yes.

10:42:06 15 Q. Okay. And these sections of  
10:42:11 16 the regulation - and if we can bring up the  
10:42:13 17 Medication IP again, 47625 - these sections of  
10:42:31 18 the regulation -- and if you need to keep your  
10:42:32 19 order open to help you, because I don't think  
10:42:36 20 we can do split screens, right.

10:42:37 21 So these -- this Medication IP,  
10:42:41 22 if we can scroll down a bit and keep going --  
10:42:58 23 yeah, we can stop there.

10:42:59 24 So this Medication IP which  
10:43:01 25 references in the right-hand corner sections of  
10:43:06 26 the Act and the regulation, they would  
10:43:08 27 correspond to these sections in your order  
10:43:14 28 where you found findings; is that fair to say?

10:43:17 29 A. Yes.

10:43:17 30 Q. Okay. So if there were ten  
10:43:23 31 findings of non-compliance with sections of the  
10:43:26 32 regulation, which you have said, right, that

10:43:30 1 would mean that there would be ten "no's"  
10:43:34 2 ticked off on a Medication IP?

10:43:37 3 A. Either within the Medication  
10:43:39 4 IP or through ad hoc, which is an ad hoc note,  
10:43:42 5 so we can pull the legislation from there as  
10:43:43 6 well.

10:43:43 7 Q. Okay, but what my question  
10:43:45 8 is, your ten findings here, they would have  
10:43:48 9 been "no's" on this, on a Medication IP such as  
10:43:54 10 this?

10:43:54 11 A. Correct.

10:43:54 12 Q. Okay. And so you would agree  
10:43:58 13 with me that when we look at this Medication IP  
10:44:04 14 in its entirety, which is what you applied to  
10:44:06 15 Meadow Park, there were ten "no's" ticked on  
10:44:13 16 this form, on a form such as this?

10:44:16 17 A. So we use a computerized  
10:44:18 18 system, it is within our IQS system, so it does  
10:44:23 19 have questions like this that we would either  
10:44:25 20 select "yes", "no", or "not applicable".

10:44:27 21 Q. They are the same questions?

10:44:28 22 A. They are.

10:44:29 23 Q. Okay. So what I am asking  
10:44:31 24 is, if you found ten non-compliances with the  
10:44:34 25 regulation, okay, which matched the questions  
10:44:38 26 on this IP, right?

10:44:39 27 A. Uhm-hmm.

10:44:40 28 Q. There would be ten boxes  
10:44:42 29 where you would have clicked or where you would  
10:44:44 30 have ticked "no" on a Medication IP or you  
10:44:46 31 would have written "no" on a Medication IP?

10:44:48 32 A. And in this circumstance, it



10:44:50 1 was a bit unusual because we issued everything  
10:44:52 2 under 114.

10:44:54 3 So for this IP, when we would  
10:44:56 4 have completed it, it would have said "no" in  
10:44:59 5 114. Because we didn't issue each  
10:45:03 6 non-compliance on its own, we issued under the  
10:45:08 7 umbrella of 114, so those might show "not  
10:45:11 8 applicable" within the IP.

10:45:13 9 Q. Okay, but even if we go  
10:45:15 10 beyond that and take the references that you  
10:45:20 11 have made in the order to the various sections,  
10:45:23 12 right, all of these sections are referenced on  
10:45:25 13 this Medication IP?

10:45:26 14 A. Yes.

10:45:27 15 Q. And so if we took the  
10:45:29 16 non-compliance with a section of the  
10:45:32 17 regulation, it would correspond to a "no" on  
10:45:35 18 one of the -- for ten questions on this  
10:45:39 19 Medication IP?

10:45:40 20 A. Yes.

10:45:40 21 Q. Okay. So then you would  
10:45:41 22 agree with me that based on that analysis, in  
10:45:44 23 completing the entire Medication IP, there  
10:45:47 24 would have been "yes's", "yes's" indicating  
10:45:51 25 compliance for 59 of the 69 questions on the  
10:45:53 26 Medication IP?

10:45:54 27 A. I'm going to assume yes, but  
10:45:57 28 I don't have my IP in front of me to confirm  
10:46:00 29 that.

10:46:00 30 Q. Okay. And if we say yes,  
10:46:03 31 that there were 59 of 69 "yes's", and you know,  
10:46:09 32 I don't expect you to do the math in your head,

10:46:12 1 but I am going to suggest to you that there was  
10:46:13 2 an 85 percent compliance with this Medication  
10:46:16 3 IP?

10:46:17 4 A. I will agree with those  
10:46:20 5 numbers.

10:46:20 6 Q. Okay, thank you. Now, the  
10:46:38 7 other day Karen Simpson testified that she felt  
10:46:44 8 that the findings of non-compliance in relation  
10:46:47 9 to the medication management system, so these  
10:46:50 10 ten findings in your order were small failures,  
10:46:56 11 were the words she used, that were not high  
10:46:58 12 risk and that individually they would not  
10:47:02 13 warrant a Compliance Order. Would you agree  
10:47:04 14 with Karen?

10:47:05 15 A. I don't recall Karen saying  
10:47:07 16 it that way.

10:47:08 17 Q. Okay, so -- and I don't want  
10:47:11 18 to misspeak, so I am going to pull Ms.  
10:47:14 19 Simpson's testimony up, and it is the public  
10:47:19 20 hearing date was July 30th, page 6263.

10:47:35 21 Sorry, do you need the page?  
10:48:16 22 Sorry, 6263. I thought I said that. I'm  
10:48:18 23 sorry.

10:48:19 24 Okay, so if we scroll down a  
10:49:33 25 little to the second paragraph, okay, and yeah,  
10:49:37 26 a little further down.

10:49:40 27 Okay, so it says here, and this  
10:49:42 28 is Karen Simpson's testimony, she says:

10:49:46 29 "So with Meadow Park, we didn't  
10:49:47 30 have these significant number of  
10:49:49 31 medication errors with no  
10:49:51 32 investigations happening. We

10:49:52 1 had -- so there are multiple  
10:49:53 2 requirements for the medication  
10:49:55 3 administration system. We had  
10:49:56 4 small failures in many different  
10:49:58 5 areas in that medication  
10:50:00 6 administration system.

10:50:01 7 When I [talked] to the  
10:50:08 8 inspectors, what [those]  
10:50:11 9 inspectors were saying to me,  
10:50:12 10 any one of those just on its own  
10:50:14 11 would not warrant an order  
10:50:16 12 because the issues were not, you  
10:50:17 13 know, the high risk, the scope  
10:50:19 14 and severity that would actually  
10:50:20 15 justify an order.

10:50:21 16 However, what you saw was  
10:50:23 17 multiple issues in many areas  
10:50:25 18 all associated with the  
10:50:28 19 medication [management] system."

10:50:31 20 Okay, so does that refresh your  
10:50:33 21 memory of her testimony?

10:50:34 22 A. Yes.

10:50:34 23 Q. Okay, so what I am asking --  
10:50:35 24 and when she says here "when I was talking to  
10:50:37 25 the Inspectors", would that have been you and  
10:50:40 26 Mr. Kikuta?

10:50:40 27 A. That's correct.

10:50:40 28 Q. Okay. So would you agree  
10:50:42 29 then with Ms. Simpson that these  
10:50:47 30 non-compliances in relation to medication  
10:50:53 31 management were small failures in many  
10:51:02 32 different areas that were not the high risk,

10:51:06 1 the scope and severity that would actually  
10:51:08 2 justify a Compliance Order? Would you agree  
10:51:11 3 with that?

10:51:11 4 A. Yes, I would.

10:51:14 5 Q. Okay. Now, you had said that  
10:51:21 6 all of these ten findings went under section  
10:51:25 7 114 into a single compliance -- into one  
10:51:28 8 Compliance Order?

10:51:28 9 A. Correct.

10:51:29 10 Q. But am I correct that in  
10:51:31 11 order to lift that Compliance Order, Meadow  
10:51:34 12 Park was not required to comply simply with  
10:51:37 13 section 114. It would have to demonstrate  
10:51:40 14 compliance in all ten of the areas?

10:51:42 15 A. Yes.

10:51:43 16 Q. Okay. And we know that that  
10:51:47 17 Compliance Order was lifted?

10:51:49 18 A. It was complied this past  
10:51:52 19 May, I believe, May 2018.

10:51:56 20 Q. Okay, that's correct, thank  
10:51:57 21 you.

10:51:58 22 Okay, and now I want to talk  
10:52:01 23 about some of the other findings that Ms.  
10:52:04 24 Stephens took you through in relation to the  
10:52:06 25 seven Written Notifications and Voluntary Plans  
10:52:09 26 of Correction.

10:52:11 27 So and when I say "seven", I  
10:52:13 28 know that there was one that was attached to  
10:52:15 29 the Compliance Order, so I am not talking about  
10:52:17 30 that one. I am talking about the other seven.

10:52:20 31 A. Okay.

10:52:21 32 Q. Now, you testified that in

10:52:27 1 respect to some of these findings, they had  
10:52:30 2 been lowered to a Written Notification and  
10:52:33 3 Voluntary Plan of Compliance due to some  
10:52:36 4 mitigating factors?

10:52:38 5 A. That we were guided by the  
10:52:40 6 fact that the incidents had occurred in 2014  
10:52:43 7 and they related to Elizabeth Wettlaufer.

10:52:45 8 Q. And also guided by the fact,  
10:52:48 9 if memory serves me correct, that in 2016 some  
10:52:52 10 of these concerns no longer existed?

10:52:54 11 A. Right, and that would have --  
10:52:56 12 if there was issues in 2014, it would have been  
10:52:58 13 supportive evidence for findings in 2016.

10:53:00 14 Q. And today, do you stand by  
10:53:05 15 your findings? Are you comfortable with those  
10:53:07 16 findings you made that these non-compliances  
10:53:11 17 justified Written Notifications and Voluntary  
10:53:13 18 Plans of Correction?

10:53:14 19 A. Yes, I am. As a team, it  
10:53:18 20 wasn't just myself that reviewed the judgment  
10:53:20 21 matrix or the reports. We also, myself and  
10:53:24 22 Neil, the London SAO Manager and Karen as well  
10:53:28 23 agreed.

10:53:29 24 Q. Okay. And just to confirm,  
10:53:32 25 when we have a Written Notification and a  
10:53:36 26 Voluntary Plan of Compliance, that means we are  
10:53:40 27 at a Level 1 or Level 2 in the judgment matrix,  
10:53:44 28 which indicates minimum risk or minimum harm or  
10:53:49 29 potential for actual harm?

10:53:50 30 A. Yes.

10:53:57 31 MS. CORRENTE: Those are my  
10:53:57 32 questions, thank you.

10:53:59 1 THE WITNESS: Thank you.

10:54:00 2 THE COMMISSIONER: Thank you.

10:54:07 3 CROSS-EXAMINATION BY MR. GOLDEN:

10:54:31 4 Q. Hi, good morning.

10:54:32 5 A. Good morning.

10:54:33 6 Q. My name is David Golden,

10:54:35 7 representing Caressant Care.

10:54:35 8 Natalie, did you receive as part

10:54:43 9 of your training to be an Inspector any

10:54:45 10 training in relation to how to understand or

10:54:49 11 interpret employee files?

10:54:51 12 A. No, we did not.

10:54:53 13 Q. And so, sorry, you didn't

10:54:59 14 receive such training?

10:55:00 15 A. Not in regards to employee

10:55:02 16 files.

10:55:02 17 Q. All right, so you wouldn't

10:55:03 18 have received any training on, for example,

10:55:06 19 understanding the grievance process in a

10:55:09 20 unionized environment and what information

10:55:11 21 might be in an employee file about the

10:55:13 22 grievance process?

10:55:14 23 A. Not as an Inspector.

10:55:17 24 Q. Okay. And so there wouldn't

10:55:20 25 have been any training about sunset clauses in

10:55:24 26 collective agreements and what potential impact

10:55:27 27 that could have on how discipline is handled in

10:55:30 28 a home?

10:55:30 29 A. No, we did not.

10:55:31 30 Q. Okay. And the concept of

10:55:32 31 progressive discipline and how that might

10:55:34 32 impact what you would see in an employee file

10:55:37 1 about the discipline, that wouldn't have been  
10:55:41 2 trained either?

10:55:42 3 A. No.

10:55:42 4 Q. And one of the counsel in  
10:55:44 5 this Inquiry so far has suggested that when  
10:55:49 6 long-term care homes are hiring, that they  
10:55:53 7 could or should pay closer attention to  
10:55:57 8 resumés, look for gaps, and that that might  
10:55:59 9 trigger some concerns.

10:56:01 10 Is that something that you have  
10:56:02 11 been trained at when you look at an employee  
10:56:04 12 file, to look for potential gaps in a resumé  
10:56:06 13 that might trigger some concerns?

10:56:09 14 A. Not the potential gaps, no.

10:56:10 15 Q. Okay. And you gave some  
10:56:15 16 evidence in your affidavit about inspecting for  
10:56:18 17 a narcotic incident. Is there any training  
10:56:24 18 that you have that says when you are inspecting  
10:56:26 19 for a narcotic incident, part of the steps  
10:56:30 20 would be to contact the College to get the full  
10:56:32 21 prior history for that nurse?

10:56:34 22 A. Not that I am aware of, no.

10:56:36 23 Q. And I take it you would be  
10:56:39 24 aware that from Find a Nurse, for example, a  
10:56:44 25 long-term care home can't get the full prior  
10:56:46 26 history of how that nurse might have been  
10:56:51 27 disciplined or interacted with the College?

10:56:53 28 A. That is my understanding from  
10:56:55 29 this Inquiry.

10:56:56 30 Q. All right. And I wrote this  
10:57:01 31 down and I just want to make sure I was  
10:57:04 32 accurate, that when you were answering

10:57:06 1 questions to Ms. Corrente, you said that with  
10:57:10 2 regard to the right of an interviewee to have  
10:57:14 3 counsel present in section 147 of the Long-Term  
10:57:18 4 Care Homes Act, you only became aware of that  
10:57:20 5 in the course of the inspection you were doing  
10:57:22 6 at Meadow Park?

10:57:22 7 A. Yeah, I never had an  
10:57:26 8 incident, an incident or a discussion that  
10:57:27 9 legal counsel -- or that staff wanted legal  
10:57:30 10 counsel present.

10:57:30 11 Q. Are you aware of any other  
10:57:33 12 section other than section 147 which sets out  
10:57:37 13 all the powers and authority that an Inspector  
10:57:42 14 has under the Act?

10:57:42 15 A. Yes, I am.

10:57:43 16 Q. Sorry, there are others?

10:57:44 17 A. Yes, there are.

10:57:44 18 Q. Which are those?

10:57:45 19 A. I would need to review the  
10:57:46 20 legislation.

10:57:47 21 Q. Can we just pull up section  
10:57:49 22 147. I think it is at page 899. There we are.  
10:57:59 23 Thank you.

10:58:00 24 This section 147 says:

10:58:04 25 "An Inspector conducting an  
10:58:05 26 inspection".

10:58:07 27 And then it lists a whole bunch  
10:58:08 28 of them.

10:58:10 29 I take it that this is the  
10:58:11 30 primary section that gives you the power to go  
10:58:14 31 in and do your inspection?

10:58:15 32 A. Yes, it does.



1 Q. And so would you not have  
2 received training on the scope or limitations  
3 on what your authority is under section 147?

4 A. We always have our inspection  
5 handbook with us, so if we were unsure, we  
6 could go back and read what our powers were.

7 Q. And is there anything in the  
8 handbook specifically about 147(1)(d)?

9 A. And I should specify it is  
10 the legislation that we carry around with us  
11 and the Act, so we would have that with us to  
12 look at and read. If I was unsure, I would go  
13 to the Act or the legislation.

14 Q. Okay, but we know what is in  
15 the Act and the legislation. Is there anything  
16 that you recall about being trained about that  
17 section?

18 A. I recall the powers that we  
19 could go into the home and request  
20 documentation and speak to anyone in the home,  
21 I do recall that from training.

22 Q. And do you also recall, if  
23 you look at -- just scroll down. Sorry, a  
24 little too far, at (c):

25 "May demand the production of  
26 records or other things that the  
27 inspector believes are relevant  
28 to the inspection from any  
29 person."

30 I take it you have been trained  
31 on the fact that you can ask any person to  
32 provide documentation?

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A. Yes.

Q. Have you ever used that power --

A. If we felt --

Q. -- outside of the home?

A. I do believe I have asked from CCAC, which would be outside of our home, in another inspection for information.

Q. Have you ever asked the College for information and relied on that as your authority?

A. No, I have not.

Q. You were here the other day when I asked Rhonda about potentially reaching out and getting an expert to assist in a unique situation that hadn't come up before, and I was characterizing the situation on October the 28th, 2016, at Caressant Care as unique.

And I am wondering, have you ever in the course of your job as an Inspector used your authority to go and consult with an expert to get some advice to help with your inspection?

A. If I have contacted police in regards to an inspection?

Q. No, I am asking if you have reached out to an expert to get --

A. As for an expert, no.

Q. All right, and are you aware that you have the authority to do that?

A. Yes.

Q. And we have heard some

11:00:49 1 evidence at least with respect to the Caressant  
11:00:51 2 Care home in Woodstock, and this came out in  
11:00:53 3 the course of the Inquiry, that ONA had  
11:00:56 4 maintained a locked cabinet of documents at the  
11:01:00 5 Woodstock home.

11:01:00 6 Have you ever in the course of  
11:01:03 7 your job as an Inspector asked to see ONA  
11:01:06 8 documents that might relate to a nurse's  
11:01:09 9 performance?

11:01:09 10 A. No, I have not.

11:01:17 11 MR. GOLDEN: Okay, I have  
11:01:18 12 nothing further. Thank you.

11:01:19 13 THE COMMISSIONER: Thank you,  
11:01:20 14 Mr. Golden.

11:01:24 15 CROSS-EXAMINATION BY MS. FRASER:

11:01:32 16 Q. Ms. Moroney, for the record,  
11:01:34 17 I am Suzan Fraser and I am here on behalf of  
11:01:36 18 OARC.

11:01:37 19 You became an RPN in 1998; is  
11:01:40 20 that correct?

11:01:40 21 A. That's correct.

11:01:40 22 Q. And then you became an RN in  
11:01:43 23 2005?

11:01:43 24 A. Yes.

11:01:44 25 Q. And then following that, in  
11:01:46 26 2006 to 2008 you were both the Assistant  
11:01:51 27 Director of Care and Director of Care at Meadow  
11:01:54 28 Park lodge?

11:01:54 29 A. Meadow Park London, yes.

11:01:55 30 Q. Meadow Park London, I see.  
11:01:59 31 And then in 2014, you became an

11:02:03 32 Inspector?

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A. Yes.

Q. And so when you were called upon to engage in the inspection at Meadow Park, did you tell your supervisor or remind your supervisor that you had worked there before?

A. Yes, she was aware that I worked there before.

Q. Okay, and did your Director know that you had worked there before?

A. We have had that conversation, yes.

Q. Okay, so she knew?

A. Yes.

Q. Okay. And I understand that you do not think that that influenced your work, but did you give consideration to the optics to any of the residents in long-term care at Meadow Park to see the former Director of Care show up to do the inspection?

A. I had already been in the home prior to that with inspections, so that the staff would have recognized me -- or the residents would have recognized me from previous inspections as well.

Q. Right, but my question related to your consideration of the optics of a former Director of Care going in as an Inspector and whether you gave consideration to those optics?

A. No, I did not.

Q. Okay. And you'll agree with

11:03:13 1 me that even if there is no actual bias, that  
11:03:18 2 there can be an appearance of bias if a former  
11:03:21 3 Director of Care shows up as the Inspector?

11:03:24 4 A. Yes, I can see that.

11:03:27 5 Q. And was there anything in  
11:03:33 6 your training about conflict of interest or  
11:03:36 7 appearance of bias?

11:03:37 8 A. No, there was not.

11:03:39 9 Q. Okay. And we have had a look  
11:03:44 10 today at the staff inventory, and my question  
11:03:49 11 for you is would you say that more than half of  
11:03:51 12 the people on that staff inventory worked at  
11:03:55 13 Meadow Park when you were the Director of Care?

11:03:58 14 A. The management team was newer  
11:04:12 15 to the home. I was not familiar with the  
11:04:14 16 management team besides previous inspections.

11:04:17 17 Q. Yes.

11:04:17 18 A. Some of the Personal Support  
11:04:21 19 Workers I do recall when I worked at Meadow  
11:04:23 20 Park London.

11:04:23 21 Q. Right.

11:04:33 22 A. And there is a possibility  
11:04:34 23 there could be half of the Personal Support  
11:04:36 24 Workers that I knew --

11:04:37 25 Q. Okay.

11:04:37 26 A. -- prior to.

11:04:38 27 Q. Right. And what about the  
11:04:39 28 nursing staff?

11:04:40 29 A. The registered staff, no.

11:05:04 30 Q. No, okay, thank you.

11:05:05 31 I would like to call up doc ID

11:05:11 32 40984, page 2, please, and that is Exhibit "B"

1 to your affidavit.

2 And just if we could go -- thank  
3 you.

4 So I understand from you  
5 yesterday that you talked about the orders that  
6 you made under section - and that is perfect -  
7 114 -- and the "that's perfect" is my  
8 instruction to Laura, so just for the record.

9 So just looking, I understood  
10 your evidence was that you determined that you  
11 were going to make your orders under section  
12 114; that's right?

13 A. That's correct.

14 Q. Okay, and that you issued one  
15 order rather than several?

16 A. That's correct.

17 Q. Okay. And the consequence,  
18 one consequence of that you would agree is that  
19 when the public looks at the compliance history  
20 of Meadow Park, they would see one Compliance  
21 Order rather than several?

22 A. Yes.

23 Q. Okay.

24 MS. CORRENTE: Well, I don't  
25 think that that's consistent  
26 with what she testified.

27 Her testimony was that on  
28 their own, they wouldn't have  
29 resulted in Compliance Orders.  
30 So it is not fair to say that  
31 the public would be seeing  
32 several Compliance Orders. The

11:06:35 1 public might potentially be  
11:06:37 2 seeing several other findings,  
11:06:39 3 but not several Compliance  
11:06:40 4 Orders.  
11:06:41 5 MS. FRASER: Commissioner, I  
11:06:42 6 understood her evidence  
11:06:43 7 yesterday was that she could  
11:06:45 8 have issued several Compliance  
11:06:48 9 Orders but chose to issue one,  
11:06:50 10 and I understood there was some  
11:06:51 11 discussion with your counsel  
11:06:53 12 about what the default would be.

11:06:56 13 And maybe I misunderstood  
11:06:57 14 that evidence, but I understood  
11:06:58 15 that she had the option here of  
11:07:00 16 issuing several orders and chose  
11:07:02 17 to issue one.

11:07:03 18 THE COMMISSIONER: Yes, I would  
11:07:05 19 encourage you to pursue that. I  
11:07:06 20 think that it is a -- there is a  
11:07:09 21 slight difference between what  
11:07:10 22 the two of you are saying, and  
11:07:13 23 if you pose it with this  
11:07:15 24 witness, it will become clear.

11:07:17 25 BY MS. FRASER:

11:07:17 26 Q. Thank you. Am I right that  
11:07:20 27 you had the option of making several Compliance  
11:07:24 28 Orders?

11:07:24 29 A. We would have to apply each  
11:07:26 30 of those non-compliances to the judgment  
11:07:29 31 matrix.

11:07:29 32 Q. Yes.

11:07:30 1 A. And that would give us our  
11:07:31 2 action. I can't say for certain that every  
11:07:34 3 single one of those ten non-compliances would  
11:07:37 4 result in an order.

11:07:39 5 Q. Yes.

11:07:39 6 A. They could result in a  
11:07:40 7 Voluntary Plan of Correction with a Written  
11:07:43 8 Notification.

11:07:43 9 Q. Okay, so -- but you did it  
11:07:49 10 all under one order, right?

11:07:51 11 A. That's correct.

11:07:51 12 Q. Okay. And the consequence,  
11:07:54 13 and just now talking theoretically, about doing  
11:07:57 14 that is if you issue one, it shows up as one on  
11:08:02 15 the website, and whatever you do in terms of a  
11:08:04 16 Voluntary Plan of Correction or a Compliance  
11:08:08 17 Order, whatever your decisions are to make one  
11:08:10 18 or more than one, that is going to go up on the  
11:08:13 19 website, right?

11:08:14 20 A. The public report would show  
11:08:16 21 all of the non-compliance under the order under  
11:08:19 22 section 114.

11:08:20 23 Q. Okay, so whatever decision  
11:08:21 24 you make in that moment, it has a potential to  
11:08:24 25 impact the public's perception of the home?

11:08:27 26 A. Yes.

11:08:29 27 Q. Okay. And it also, as I  
11:08:31 28 understand, impacts the LRPA, am I right about  
11:08:38 29 that, and that is the Long-Term Care Home  
11:08:41 30 Quality Inspection Program Risk and Performance  
11:08:45 31 Assessment Report?

11:08:45 32 A. I'm not as familiar with that



1 report.

2 Q. Okay, we are going to hear  
3 from Mr. Moorman about that. Do you know that  
4 the decision in that moment has an impact on  
5 that score?

6 A. I do not. As an Inspector,  
7 it would be our managers that would have that  
8 information.

9 Q. Okay. And then just finally,  
10 yesterday you said that you were a bit  
11 surprised to find the letter of reference in  
12 the employment file?

13 A. I was.

14 Q. Is that a bit of an  
15 understatement? You sounded very diplomatic  
16 when you were saying that. Is it fair to say  
17 that you were very surprised?

18 A. When a nurse is terminated  
19 from a home related to medication incidents  
20 that directly affected the residents, it is  
21 surprising to see a reference letter like that.

22 Q. Right, and it is not a bit  
23 surprising. It is very surprising, right?

24 A. Yes.

25 MS. FRASER: Thank you. I don't  
26 have any other questions.

27 THE COMMISSIONER: Thank you,  
28 Ms. Fraser.

29 MS. STEPHENS: I'm just  
30 canvassing the room, and I think  
31 that may be it for  
32 cross-examination. Any

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re-examination?

MS. MINGO: Just one question.

RE-EXAMINATION BY MS. MINGO:

Q. Just one brief question for you, Natalie.

Mr. Golden had asked you if you had ever received any training in interpreting an employee file or any training on sort of looking at a file in the context of a unionized environment.

Now, my understanding is that you worked in a management position at Meadow Park London as a Director of Care and an Assistant Director of Care; is that correct?

A. Yes.

Q. Is Meadow Park London a unionized home?

A. Yes, it is.

Q. So you have experience working as a manager in a unionized home?

A. Yes, I do.

MS. MINGO: Thank you, those are all my questions.

THE COMMISSIONER: Thank you very much.

Any re-examination?

MS. STEPHENS: I have no re-examination, no.

THE COMMISSIONER: All right, then that means that you are free to go. I would like to thank you on behalf of the

11:10:44 1 Inquiry for all your help.  
11:10:45 2 THE WITNESS: Thank you very  
11:10:46 3 much.  
11:10:55 4 MS. STEPHENS: So our next  
11:10:57 5 witness will be Lisa Vink.  
11:10:59 6 I am wondering if we should  
11:11:00 7 perhaps take a morning break and  
11:11:04 8 we can get through Ms. Vink  
11:11:09 9 after that.  
11:11:10 10 I believe I will be fairly  
11:11:11 11 brief in my examination, and my  
11:11:15 12 understanding from counsel  
11:11:16 13 yesterday is there are not that  
11:11:18 14 many participants who will be  
11:11:20 15 cross-examining today.  
11:11:21 16 So I wonder if we take our  
11:11:23 17 morning break and we sit a  
11:11:25 18 little bit longer, if we might  
11:11:27 19 be able to complete her by a  
11:11:30 20 later lunchtime.  
11:11:32 21 THE COMMISSIONER: That sounds  
11:11:33 22 very nice on the part of  
11:11:34 23 everyone, I think. It is a long  
11:11:35 24 weekend coming up.  
11:11:37 25 So absolutely, we'll take our  
11:11:38 26 morning recess now.  
11:11:39 27 -- RECESSED AT 11:11 A.M. --  
11:15:34 28 -- RESUMED AT 11:25 A.M. --  
11:18:46 29 MS. STEPHENS: Commissioner, I'd  
11:31:34 30 like to call our next witness,  
11:31:36 31 Lisa Vink.  
11:31:40 32 THE COMMISSIONER: Come forward,

11:31:43 1 Ms. Vink. Thank you.

11:31:43 2 LISA MARIE VINK: SWORN.

11:31:43 3 EXAMINATION-IN-CHIEF BY

11:31:43 4 MS. STEPHENS:

11:32:42 5 Q. So good morning, Ms. Vink.

11:32:44 6 As you may have noticed, we have adopted a

11:32:48 7 custom when a witness begins with asking them

11:32:50 8 what their preference is in terms of whether

11:32:51 9 you'd like to be addressed by your first or

11:32:55 10 your last name.

11:32:56 11 A. My first name, please.

11:32:58 12 Q. So Lisa. Thank you.

11:32:59 13 Lisa, do you recall swearing an

11:33:00 14 Affidavit for the purpose of this inquiry?

11:33:02 15 A. I do.

11:33:02 16 Q. Okay. And that should be

11:33:04 17 there in front of you. I'd just ask you to

11:33:09 18 flip to the final page of the Affidavit, which

11:33:10 19 will be right before Tab A. And can you

11:33:14 20 confirm that that's your signature?

11:33:15 21 A. That is my signature.

11:33:16 22 Q. Okay. And are there any

11:33:17 23 changes you would like to make to the Affidavit

11:33:20 24 at this time?

11:33:20 25 A. There are not, no.

11:33:22 26 MS. STEPHENS: So, Commissioner,

11:33:23 27 I'd like this to be the next

11:33:25 28 exhibit at our hearings.

11:33:26 29 THE COMMISSIONER: Yes.

11:33:27 30 Thank you. So Exhibit Number

11:33:28 31 144, Affidavit of Lisa Vink.

11:33:30 32 EXHIBIT NO. 144: Affidavit of

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Lisa Vink.

BY MS. STEPHENS:

Q. So, Lisa, I understand you've been a Registered Nurse since 1992; is that right?

A. That is correct.

Q. And you have worked in both municipal homes for the aged and a nursing home as a Registered Nurse?

A. Yes.

Q. And you also worked as an Acting Director of Nursing and a Director of Nursing in those homes?

A. Not in both of the homes. Just in the municipal homes.

Q. In the municipal homes?

A. Correct.

Q. Okay. Thank you.

A. At the nursing home, I only worked as a Registered -- I shouldn't say "only." I worked as a Registered Nurse.

Q. Okay. Thank you. And I understand you joined the Ministry as a compliance advisor back in 2000.

A. Yeah.

Q. Is that right?

And so that was actually before the service area offices, as we know them, existed; is that right?

A. Yes.

Q. So you were at the Central South Regional Office, which is in Hamilton?

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A. That's correct.

Q. And that office ultimately became the Hamilton Service Area Office?

A. Yes.

Q. Okay. So I want to briefly ask you about the role of compliance advisor and what it was like to be a compliance advisor as opposed to an inspector now, because we have heard people asking about that process, and your name has come up as someone who might be able to answer some questions.

So we know when you were a compliance advisor -- we know that compliance advisors were assigned to specific homes; is that right?

A. Yes, that is correct.

Q. And do you recall about how many homes would have been assigned to you?

A. Somewhere between the neighbourhood of 12 to 15. I can't remember exactly for sure, but around that neighbourhood.

Q. And you were -- as I understand it, you would be responsible for essentially handling everything to do with that home, dealing with all the information you'd received from those homes?

A. That is correct. We would receive -- the homes would call us directly. Our phone number would be posted. So we would receive all of the mailings that came in from that home in relation to compliance issues.

1 We would be responsible for  
2 their reviews, which are now -- have evolved  
3 into inspections, so yes.

4 Q. And you would also receive  
5 the complaints about those homes too; is that  
6 right?

7 A. That is correct.

8 Q. Okay. And can you just tell  
9 us a little bit about what the nature of those  
10 reviews were. When you went into a home, how  
11 would you approach those reviews?

12 A. So we did a -- we had a  
13 number of different types of reviews. We could  
14 do annual reviews, which have evolved into the  
15 Resident Quality Inspection. We also could do  
16 complaint reviews, unusual occurrences which  
17 have now involved (sic) into Critical Incident  
18 Reports.

19 We also did pre-occupancy and  
20 post-occupancy reviews. So when a home was  
21 first being built or after it had first opened  
22 or even if they were just renovating a section  
23 of the home, we would have to go in before  
24 residents moved into the home, things like  
25 that.

26 We also could do other  
27 inspections which could sort of be a whole  
28 different variety of things. So those were the  
29 type of reviews that we did at that time.

30 Q. Okay. And when you went in  
31 for the annual reviews or the reviews in  
32 relation to complaints or unusual occurrences,

11:36:48 1 you would be inspecting against those standards  
11:36:51 2 and criteria that are in the long-term care  
11:36:54 3 homes program manual?

11:36:57 4 A. The Long-Term Care Facility  
11:36:57 5 Program Manual, yes. So we didn't have Ontario  
11:37:00 6 Regulation 79/10 in the Long-Term Care Homes  
11:37:02 7 Act at that time.

11:37:03 8 We had a Long-Term Care Facility  
11:37:05 9 Program Manual, which set out standards, and  
11:37:07 10 then within those standards were the specific  
11:37:10 11 criterion to reflect those standards.

11:37:14 12 We also had, at that time, three  
11:37:16 13 different pieces of legislation that were  
11:37:19 14 specific to the different type of homes.

11:37:21 15 So the Nursing Home Act was  
11:37:22 16 relevant to nursing homes, Charitable  
11:37:24 17 Institutions Act to homes that were run by the  
11:37:26 18 charitable institutions, and then the Homes for  
11:37:31 19 the Aged and Rest Homes Acts, which would be  
11:37:32 20 the municipal homes.

11:37:33 21 Q. Okay. And if you found that  
11:37:36 22 a home was not complying with the standards and  
11:37:40 23 criteria from that -- from that manual, what  
11:37:44 24 could you do? What were the options open to  
11:37:47 25 you?

11:37:47 26 A. So we would conduct a review  
11:37:51 27 if we determined that the home was not -- I  
11:37:55 28 don't know if we used the word "complying" back  
11:37:59 29 then, but I don't remember what the word was.

11:38:01 30 But if we found that they  
11:38:03 31 weren't consistent with that, we could issue  
11:38:05 32 them a report of unmet standards or criteria,



1 or we could leave them a report of observation  
2 and discussion. So we had two different types  
3 of report that we could leave in the home.

4 Q. And explain to us, what was  
5 the difference between those two reports?

6 A. Sure. So the report of unmet  
7 standards of criteria would identify what the  
8 issue was, the actual standard or criterion  
9 that was not met. That's what we called them,  
10 not met. So there you go.

11 Followed by what the specific  
12 criterion was, and our examples, very  
13 vaguely-worded examples, and then as well as it  
14 required the home to submit a plan of  
15 corrective action.

16 If we left information on an  
17 observation discussion point, the home was not  
18 required to submit a plan of corrective action.

19 And it wasn't necessarily only  
20 concerns. We would also put on their  
21 recommendations or positive things that we  
22 noted while we were in the home, suggestions  
23 for maybe future visits, things like that.

24 Q. Okay. So in your Affidavit  
25 at paragraph 18, you indicate that you believe  
26 that Critical Incident Reports received today  
27 are more likely to be inspected than the  
28 Unusual Occurrence Reports that were received  
29 under the old regime. Can you explain that to  
30 us?

31 A. Sure. Previously, the  
32 Unusual Occurrence Reports -- although, they

11:39:33 1 did evolve at some time. I can't exactly say  
11:39:36 2 when that was. It was a longhand written  
11:39:39 3 document that the home would complete, would  
11:39:41 4 tear off. They would maintain one copy. The  
11:39:43 5 other copy would be usually mailed to us.

11:39:46 6 We, as compliance advisors, each  
11:39:50 7 received, as I said, all the mailings for that  
11:39:52 8 home. So we would receive the unusual  
11:39:54 9 occurrences for each homes in our group.

11:39:56 10 And basically we looked at them  
11:39:58 11 to see what was the issue? What did the home  
11:40:00 12 do about it? How were they looking at  
11:40:03 13 preventing reoccurrence? What are the  
11:40:06 14 long-term actions and the short-term actions?  
11:40:08 15 Basically what's included in the Critical  
11:40:11 16 Incident Report that we see today.

11:40:13 17 And then we would look at that  
11:40:15 18 and determine has appropriate action been  
11:40:18 19 taken? Is everything okay? And if yes, then  
11:40:20 20 we would basically sign it and put it away.

11:40:23 21 We could call the home about it  
11:40:24 22 if we -- maybe there was something, and it  
11:40:27 23 wasn't clear or we thought -- you know, we just  
11:40:29 24 wanted to have a discussion, or we could go out  
11:40:32 25 and do a review on it.

11:40:33 26 But definitely provided that all  
11:40:36 27 the necessary or appropriate information was  
11:40:39 28 there, would probably be a better choice of  
11:40:43 29 words. Frequently it would get signed and  
11:40:45 30 filed.

11:40:46 31 Q. Okay. So we've heard that  
11:40:49 32 one of the big changes from the role of

11:40:53 1 compliance advisor to inspector was the  
11:40:57 2 elimination of the advisory role and giving of  
11:41:02 3 advice.

11:41:03 4 Can you tell us -- as a  
11:41:04 5 compliance advisor, tell us a little bit about  
11:41:06 6 the advice you would give to homes and even --  
11:41:09 7 give us an idea of how often you would be  
11:41:12 8 providing homes with advice.

11:41:13 9 A. So the types of advice would  
11:41:18 10 vary significantly based on the questions being  
11:41:20 11 asked of us. It could be anything at all under  
11:41:23 12 the sun.

11:41:24 13 You know, I've had all this  
11:41:25 14 missing laundry, and what's a way to sort of  
11:41:30 15 sift through that and sort through it.

11:41:31 16 And you could say, "Oh, you  
11:41:33 17 know, I know of a home down the road that has a  
11:41:36 18 great form. They've given me the form.  
11:41:39 19 They've given me permission to share it. This  
11:41:43 20 might be a good tool for you to use" or  
11:41:43 21 something to that effect.

11:41:45 22 There might also be homes that  
11:41:47 23 would call and say, "Oh, you know, we've --  
11:41:49 24 we're trying to review our program on getting  
11:41:56 25 residents to activities. How do we do that?"

11:42:00 26 And, again, we could say, "Oh,  
11:42:01 27 you know, this is sort of one way that that's  
11:42:04 28 been done."

11:42:04 29 It wouldn't be unusual as well  
11:42:07 30 that homes would call for -- do you know of any  
11:42:10 31 other resources to help with this challenging  
11:42:12 32 resident or things like that.

11:42:13 1 Sort of, I think, it was the  
11:42:15 2 thought that because we had the opportunity to  
11:42:18 3 go into so many different homes, we could see  
11:42:20 4 the different things that were out there and  
11:42:23 5 available.

11:42:23 6 A lot of homes were willing to  
11:42:25 7 share, so I did have a folder quite large of --  
11:42:32 8 I wouldn't say they were, you know, the gold  
11:42:35 9 standard forms, but different approaches that  
11:42:37 10 people could consider when developing forms and  
11:42:41 11 tools.

11:42:41 12 Because at that time, that was  
11:42:42 13 sort of the day of the pen and paper and before  
11:42:44 14 things were electronic as well, so...

11:42:47 15 Q. Okay. And did homes find  
11:42:50 16 that advice useful?

11:42:52 17 A. Sometimes they did.  
11:42:53 18 Sometimes we didn't have information that was  
11:42:56 19 helpful or useful to them. It just depended.

11:43:00 20 I mean, sometimes they might  
11:43:03 21 have tried a part of it or none of it and found  
11:43:04 22 it helpful or maybe it might have been  
11:43:07 23 something just to help them. "Oh, yeah, I  
11:43:09 24 never thought of that, but I think this would  
11:43:09 25 work better."

11:43:11 26 Just a starting point to kick  
11:43:11 27 off another idea that they might have had.  
11:43:17 28 Just someone else to look outside the box.  
11:43:17 29 Different set of eyes sometimes.

11:43:19 30 Q. So then when you became an  
11:43:21 31 inspector, you stopped giving advice; correct?

11:43:24 32 A. I stopped giving advice to

11:43:26 1 that degree. That is correct. Still  
11:43:28 2 definitely as Rhonda communicated, we ask  
11:43:33 3 questions, and that definitely puts people in  
11:43:36 4 a -- in a certain direction and gives them the  
11:43:38 5 answers to their questions all by themselves  
11:43:41 6 frequently.

11:43:41 7 Q. Can you give us an example of  
11:43:44 8 that?

11:43:44 9 A. There's been lots of times  
11:43:47 10 when a home will -- when we've identified  
11:43:50 11 noncompliance with a concern. And I'm so  
11:43:55 12 sorry. I don't remember if Rhonda spoke about  
11:43:59 13 clinically appropriate skin assessment or a  
11:44:02 14 falls assessment tool, but that's a frequent  
11:44:02 15 one that we...

11:44:03 16 A lot of times, for example,  
11:44:06 17 homes will have a falls-risk tool and think  
11:44:09 18 that that is sufficient, but it's not  
11:44:09 19 necessarily a clinically appropriate assessment  
11:44:11 20 post falls.

11:44:11 21 So it gets to, "So what is this  
11:44:14 22 tool exactly?"

11:44:16 23 "Well, that's a risk tool."

11:44:17 24 "Okay. So is that the same as  
11:44:19 25 this?"

11:44:19 26 "Oh, no."

11:44:20 27 "Oh, okay then."

11:44:21 28 So then again, that leads them  
11:44:23 29 to what we would expect according to the  
11:44:29 30 Regulation 49.

11:44:30 31 Q. Okay. So I want to shift  
11:44:34 32 gears and fast-forward to the fall of 2016 and

11:44:39 1 ask you about the inspection that you end up  
11:44:43 2 conducting at Telfer Place.

11:44:46 3 So at this point, you're an  
11:44:48 4 inspector?

11:44:48 5 A. I am, yes.

11:44:49 6 Q. So can you tell us how it was  
11:44:52 7 that you end up being assigned to work on that  
11:44:55 8 Telfer Place inspection in relation to  
11:44:58 9 Elizabeth Wettlaufer?

11:44:58 10 A. Kind of like my colleagues, I  
11:45:02 11 felt I was sort at the wrong place at the wrong  
11:45:05 12 time. Happened to be in the office that day  
11:45:06 13 when the email was received by my manager,  
11:45:08 14 Karin Fairchild.

11:45:10 15 She called me into her office  
11:45:12 16 and showed me the email and said this was now  
11:45:17 17 my inspection to complete.

11:45:18 18 Q. Okay.

11:45:19 19 A. That was the email that  
11:45:21 20 Karen Simpson had received by a lady. I'm so  
11:45:31 21 sorry. I cannot remember her name right now.

11:45:32 22 Q. Is that the email from  
11:45:33 23 Candace Chartier?

11:45:35 24 A. Yes. Thank you very much for  
11:45:36 25 that. Yes.

11:45:37 26 Q. So we heard from both Rhonda  
11:45:40 27 and Natalie that they were asked to go to the  
11:45:45 28 respective homes, Caressant Care and Meadow  
11:45:48 29 Park, on that same day to collect  
11:45:50 30 documentation. Were you asked to do the same  
11:45:51 31 thing?

11:45:52 32 A. I was not.

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Q. Okay.

A. I was in the home in the Hamilton Service Area -- I was not in the home. I'm sorry. I was in the Hamilton Service Area Office, which is located in Hamilton.

And we had another inspector who was working much closer to Telfer Place and Paris. Her name is Lesley Edwards, a respected colleague of mine. She was contacted and asked if she could go to the home to collect the documents.

Q. Okay. Did she do that that same day?

A. She did.

Q. Okay. And do you -- can you tell us what documents she retrieved from the home that day?

A. Sure. At the time that Lesley visited the home, she asked for the staffing schedules for the period of time that EW worked.

She asked for a listing of discharges or deaths in the home during the time that EW was working at the home, and I believe she also asked for any hospital transfers during that time as well.

Q. Okay.

A. Possible transfers of residents. Sorry, I should confirm that.

Q. And she was given all those documents?

A. Yes, I believe she was.

1 Q. Okay. So I want to ask you a  
2 little bit about the Inspection Plan that you  
3 prepared for this inspection. You say in your  
4 Affidavit that it was -- in fact, ends up being  
5 a bit different from the plans that are  
6 prepared for Caressant Care and Meadow Park.

7 Can you explain to us why that  
8 was the case?

9 A. Yes. So this has also been  
10 the first case that I've had the opportunity to  
11 work with an inspector from another service  
12 area office to develop a plan. Normally that's  
13 something that we do by ourselves.

14 And during the course of Rhonda  
15 and I working on the plan, it became evident  
16 quite quickly that some of the issues that she  
17 would have to look at were different than ours.

18 And the one that I've mentioned  
19 in the Affidavit is in the case of Telfer  
20 Place, a home that I knew to be a small 45-bed  
21 home, she was not a regular employee of the  
22 home. She was an agency staff member.

23 So there would be some  
24 differences there in relation to did the home  
25 still meet the burden of a 24/7 RN in the home  
26 at all times, things like that.

27 So some of the questions that we  
28 would ask in the IP would be different based on  
29 that.

30 Q. Okay. So before -- we also  
31 know there's a period of time before you  
32 actually return to the home. You have the



11:48:30 1 documents from the home. Did you review those  
11:48:31 2 documents?

11:48:31 3 A. We did. There wasn't a lot  
11:48:33 4 of -- although we asked for the list of ER  
11:48:38 5 transfers and hospitalizations or -- and  
11:48:41 6 discharges and deaths, it only included a  
11:48:43 7 resident's name and a date. It didn't include  
11:48:47 8 cause of death or where they had passed away,  
11:48:47 9 things like that.

11:48:50 10 So there wasn't a lot of  
11:48:51 11 documentation to review, but definitely we were  
11:48:53 12 able to reference the date that she worked and  
11:48:55 13 the date that things happened. Whether they  
11:48:57 14 were related or not, we had no way of knowing  
11:49:01 15 at all.

11:49:02 16 So we did look at the documents,  
11:49:04 17 but they didn't provide us with a lot of  
11:49:06 18 information.

11:49:06 19 Q. Okay.

11:49:07 20 A. I should add that we did have  
11:49:09 21 one other thing at this stage of the game. And  
11:49:12 22 I'm sorry. I neglected to mention it before.

11:49:14 23 The home had also submitted a  
11:49:16 24 Critical Incident Report in relation to the  
11:49:18 25 information that they were provided by the  
11:49:20 26 police.

11:49:21 27 This report -- the Critical  
11:49:22 28 Incident Report was submitted the same day that  
11:49:25 29 we had received the email and then was amended,  
11:49:28 30 I believe, the next day or the following day  
11:49:31 31 with a little bit more information, so yeah.

11:49:34 32 Q. Okay. And in your Affidavit,

11:49:35 1 you, in fact, say that that amended Critical  
11:49:40 2 Incident Report was perhaps one of the most  
11:49:41 3 useful documents you reviewed?

11:49:43 4 A. Definitely. The original  
11:49:45 5 email that we had received identified that --  
11:49:48 6 that there was a murder at Telfer Place.

11:49:52 7 So when we received the Critical  
11:49:55 8 Incident Report, the victim was identified as  
11:49:56 9 well as it identified that the victim was still  
11:50:00 10 a resident in the home.

11:50:01 11 It also identified that the home  
11:50:03 12 had done a record search themselves of this  
11:50:08 13 resident, and they were able to identify a time  
11:50:09 14 frame where the resident had had a change in  
11:50:12 15 condition as well as identify a Registered  
11:50:15 16 Nurse by -- a different Registered Nurse than  
11:50:19 17 EW who had, quote, fixed the problem or had  
11:50:22 18 provided appropriate care and assistance to the  
11:50:25 19 resident to manage her low blood glucose  
11:50:28 20 levels.

11:50:29 21 Q. Okay. Okay. And just so  
11:50:32 22 that we're clear, because we've heard a lot of  
11:50:34 23 different evidence in the facilities phase, the  
11:50:37 24 victim from this home was Sandra Towler?

11:50:43 25 A. That is correct.

11:50:43 26 Q. Okay. And the nurse who had,  
11:50:45 27 as you said, fixed the problem, do you recall  
11:50:48 28 her name?

11:50:50 29 A. I do. Diane Beauregard, and  
11:50:53 30 she was here during the facilities phase.

11:50:55 31 Q. Okay. Thank you. I  
11:50:56 32 understand you also reviewed the compliance

11:50:59 1 history from Telfer Place before going in for  
11:51:02 2 the inspection?

11:51:02 3 A. I did. That's part of the  
11:51:04 4 standard preparation process that we pull -- or  
11:51:07 5 have the compliance history pulled. That's not  
11:51:10 6 actual some -- I don't do that. That's done by  
11:51:13 7 one of the administrative assistants.

11:51:15 8 Q. Okay. And when you reviewed  
11:51:16 9 that, was there anything noteworthy in their  
11:51:20 10 compliance history?

11:51:20 11 A. It reminded me of a few  
11:51:24 12 things. It reminded me of that we had issued  
11:51:27 13 previously a concern in relation to Section 31  
11:51:29 14 about staffing in the home. There was also a  
11:51:32 15 concern identified in there in relation to  
11:51:34 16 medications.

11:51:35 17 Q. Okay.

11:51:35 18 A. Just some other -- Plan of  
11:51:42 19 Care stuff, things like that.

11:51:42 20 Q. Okay.

11:51:43 21 A. Yeah. It wasn't a  
11:51:44 22 comprehensive review. It was a quick scan of  
11:51:47 23 the document and just to kind of see what was  
11:51:51 24 there.

11:51:51 25 Q. Okay. And when you say it  
11:51:54 26 reminded you, had you been in Telfer Place  
11:51:57 27 before doing inspections?

11:51:58 28 A. Definitely, yes.

11:51:59 29 Q. Okay. So, Lisa, I want to  
11:52:01 30 fast-forward to when you're actually back in  
11:52:03 31 the home and you start your inspection. And  
11:52:06 32 I'm going to ask you to walk us through what

11:52:10 1 happened when you actually go on-site for that  
11:52:12 2 inspection.

11:52:12 3 I'm more interested in the stage  
11:52:16 4 and the process, so the steps you took and what  
11:52:17 5 you were looking for than your actual findings,  
11:52:20 6 because we will go to your actual report from  
11:52:23 7 the inspection to look in some detail at those  
11:52:26 8 findings.

11:52:26 9 But to start off, I understand  
11:52:28 10 you actually were not one of the two inspectors  
11:52:31 11 that was first in the home; is that right?

11:52:34 12 A. That is accurate.

11:52:35 13 Q. Okay. So can you explain  
11:52:37 14 that? And tell us how this inspection started.

11:52:39 15 A. Sure. So Lesley Edwards, who  
11:52:45 16 was the inspector that first attended the home  
11:52:47 17 to get those initial documents, and another  
11:52:51 18 respected colleague, Phyllis Hiltz-Bontje, they  
11:52:53 19 attended the home.

11:52:54 20 They met with the acting  
11:52:56 21 Director of Nursing at the time. They -- I'm  
11:53:06 22 so sorry. I don't recall if the Acting  
11:53:09 23 Executive Director was there at the time. For  
11:53:12 24 some reason, I think it was only the Acting  
11:53:15 25 Director of Nursing.

11:53:17 26 They met with her. They had  
11:53:21 27 collected some policies and procedures at that  
11:53:22 28 time. They had requested a copy of the  
11:53:25 29 victim's clinical records, her Progress Notes.

11:53:27 30 They had conducted some  
11:53:29 31 medication observations with staff that were  
11:53:30 32 there, although did not actually interview the

11:53:34 1 staff, but only conducted the observations.

11:53:37 2 Q. Can I pause you there?

11:53:39 3 A. Of course.

11:53:39 4 Q. We've heard that there were

11:53:43 5 sort of -- there was a unique approach to

11:53:46 6 interviews for these inspections because there

11:53:49 7 were some limits on who you could speak to.

11:53:52 8 Was that also true for Telfer Place?

11:53:54 9 A. Definitely, yes.

11:53:55 10 Q. Okay.

11:53:55 11 A. So initially -- and I've only

11:53:59 12 heard this from my colleagues, but initially

11:54:02 13 they were instructed not to interview anyone,

11:54:02 14 that they could speak with the Director of

11:54:05 15 Nursing or the Executive Director. I'm sorry.

11:54:06 16 I don't recall who the individual was. But not

11:54:09 17 to interview the staff.

11:54:11 18 And then they were also

11:54:13 19 instructed to -- when they were identifying

11:54:16 20 which staff they wanted to talk to, they would

11:54:18 21 need to submit the name of the staff member to

11:54:21 22 our manager.

11:54:22 23 That name or that individual

11:54:24 24 would be -- the name of that individual would

11:54:27 25 be forwarded up, and then we would later get

11:54:30 26 direction as to when we could talk to them.

11:54:33 27 Interviews typically as well,

11:54:35 28 when I conduct an inspection, are done starting

11:54:38 29 at the frontline staff and then working up to

11:54:40 30 registered staff or the supervisor if it's

11:54:45 31 housekeeping or something that I'm looking at,

11:54:47 32 but in this case, we also didn't start that

1 way.

2 We sort of had to start from a  
3 different place in that we were very limited as  
4 well as to what we could talk with the staff  
5 about.

6 The difference between our  
7 inspection and the other inspections that were  
8 conducted is that there were no charges laid in  
9 relation to Sandy Towler at this time when we  
10 were in the home in October and November. It  
11 wasn't until January that charges were laid.

12 So although staff in the home  
13 knew that they had worked with the nurse and  
14 were aware that she was in the media, it was  
15 not at all related to their home at that time.

16 So we needed to be very -- we  
17 were cautioned repeatedly that we don't want to  
18 do anything at all to jeopardize the police  
19 investigation, so you need to be cautious as to  
20 what you say as to not share too much  
21 information and potentially -- yeah.

22 Q. Okay. Okay. So as I  
23 understand it from your Affidavit, you join  
24 Lesley and --

25 A. Phyllis.

26 Q. -- Phyllis on-site on  
27 November 9th; is that correct?

28 A. I would have to check my  
29 Affidavit. That sounds about right, but I'm  
30 sorry. I don't remember the exact date right  
31 now.

32 Q. Okay. And so when did they

11:56:14 1 go into the home? Do you know when they went  
11:56:16 2 in?

11:56:16 3 A. I'm so sorry. Dates are not  
11:56:18 4 my... Think I could find it quickly.

11:56:44 5 Q. I think paragraph 66 is  
11:56:46 6 when --

11:56:46 7 A. Oh, I was getting there.  
11:56:48 8 Okay. Thank you for your assistance.

11:56:50 9 So I did return to work on  
11:56:51 10 November the 9th. And did we identify earlier  
11:56:56 11 when they attended?

11:56:56 12 Q. It doesn't look like --

11:57:00 13 A. No. However, if we go to a  
11:57:01 14 copy of the inspection report.

11:57:04 15 Q. Can we pull that up maybe?  
11:57:06 16 It is --

11:57:07 17 A. I've just found it actually.

11:57:08 18 Q. Okay.

11:57:09 19 A. The date on there would  
11:57:12 20 suggest that they visited on October the 28th.

11:57:15 21 Q. Okay. Okay.

11:57:16 22 A. That was their first day to  
11:57:19 23 actually inspect. Then they went back  
11:57:21 24 November 1st, 3rd, and 4th. And then Phyllis  
11:57:25 25 stepped out and did not return in that I was  
11:57:30 26 now present.

11:57:30 27 Q. Okay. Okay. So by the time  
11:57:34 28 that you had arrived on November 9th, what had  
11:57:37 29 been completed then? You talked to us a little  
11:57:40 30 bit. They've collected policies and  
11:57:43 31 procedures. Had there -- what else had  
11:57:45 32 happened?

11:57:45 1 A. They had done quite bit of  
11:57:49 2 the medication IP. All that we had really left  
11:57:51 3 to do was some final interviews.

11:57:56 4 Q. Okay.

11:57:57 5 A. I believe they'd already  
11:57:58 6 started on reporting and complaints as well.  
11:58:01 7 They had done a number of observations in the  
11:58:03 8 home in relation to medications, in relation to  
11:58:09 9 the medication room, storage of medications in  
11:58:11 10 relation to staff-to-resident interactions,  
11:58:15 11 things like that.

11:58:16 12 Q. Okay. So --

11:58:20 13 A. They collected more policies  
11:58:21 14 and procedures, had started to talk to some  
11:58:23 15 staff in relation to -- when I say "staff," I  
11:58:26 16 mean management staff -- in relation to College  
11:58:32 17 of Nurses, certificate of competences.

11:58:34 18 I believe they actually started  
11:58:35 19 to collect some records on training as well  
11:58:39 20 prior to my arrival.

11:58:40 21 Q. Okay. And why the records on  
11:58:43 22 training? We didn't hear about that from the  
11:58:46 23 other two inspections, so what were you looking  
11:58:48 24 for with respect to training?

11:58:50 25 A. It was part of our Inspection  
11:58:53 26 Plan, hence we wanted to ensure that the staff  
11:58:55 27 that were working were provided the mandatory  
11:59:00 28 training prior to starting in the home.

11:59:01 29 Q. Okay. Okay. Lisa, I've got  
11:59:05 30 two different documents here. I'm going to  
11:59:09 31 have Ms. Kinkartz bring those up. And I want  
11:59:13 32 you to take a look -- we have three copies.



11:59:21 1 A. I see my colleague typed  
11:59:24 2 those out, and ours was handwritten. So sorry  
11:59:26 3 about that. Thank you.

11:59:30 4 Q. For the record, these are doc  
11:59:36 5 ID 41654 and 41655. So, Lisa, can you tell us,  
11:59:43 6 what are these documents?

11:59:44 7 A. It's actually one document,  
11:59:48 8 page 1 and page 2 of the document.

11:59:50 9 Q. Okay.

11:59:50 10 A. And it's the staff inventory  
11:59:53 11 list. So these were the staff that we spoke  
11:59:55 12 with in the home at the time of the inspection.

11:59:57 13 Q. Okay.

11:59:57 14 A. They are identified by a  
11:59:59 15 number, their name, and then their position.

12:00:02 16 Q. So is everyone on the list  
12:00:04 17 someone that you spoke to in the home or --

12:00:07 18 A. No. A couple of the staff we  
12:00:09 19 had only looked at their records, not  
12:00:12 20 necessarily spoke with them, but we didn't know  
12:00:15 21 if they would be someone that we might have to  
12:00:19 22 speak with.

12:00:19 23 To identify who those were right  
12:00:21 24 now, I can't say for sure. I believe it would  
12:00:24 25 be some of the top registered staff.

12:00:25 26 Q. Okay. And I believe  
12:00:27 27 Elizabeth Wettlaufer's name appears on that  
12:00:29 28 list.

12:00:29 29 A. And we did not interview  
12:00:31 30 Elizabeth Wettlaufer. We were instructed not  
12:00:33 31 to. She wasn't available to us anyways.

12:00:35 32 Q. Okay. So as I understand it,

12:00:36 1 the list also produces -- sets a number for  
12:00:41 2 each of them. And then your report -- when  
12:00:44 3 you're referring to staff members by number in  
12:00:47 4 the report, it corresponds to this particular  
12:00:50 5 list; is that right?

12:00:51 6 A. Ideally it should, yes.

12:00:52 7 Q. Okay.

12:00:53 8 A. Yes.

12:00:54 9 Q. Okay.

12:00:54 10 MS. STEPHENS: So, Commissioner,

12:00:56 11 I would like to ask that these

12:00:57 12 be made the next exhibit.

12:00:59 13 Perhaps since we now know it's

12:01:01 14 one document, not two, perhaps

12:01:03 15 we could put it together as the

12:01:05 16 next exhibit because it will

12:01:07 17 help us make sense of the

12:01:09 18 inspection reports.

12:01:10 19 THE COMMISSIONER: All right.

12:01:12 20 Thank you. So Exhibit 145,

12:01:14 21 then, is a two-page staff

12:01:16 22 inventory list with a date of

12:01:18 23 review of October 5, 2016.

12:01:15 24 EXHIBIT NO. 145: Two-page staff

12:01:16 25 inventory list dated October 5,

12:01:26 26 2016.

12:01:29 27 BY MS. STEPHENS:

12:01:30 28 Q. So, Lisa, about how many

12:01:33 29 people would you say you interviewed in the

12:01:35 30 home while you were there?

12:01:37 31 A. When you say "people," do you

12:01:38 32 mean staff?

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12:02:29 22  
12:02:31 23  
12:02:34 24  
12:02:37 25  
12:02:39 26  
12:02:41 27  
12:02:43 28  
12:02:45 29  
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12:02:50 31  
12:02:54 32

Q. Staff.

A. I'm going to guess, based on this, that it's 31.

Q. 31. Okay. And what about in terms of -- did you interview other people? Did you interview residents?

A. We did interview -- we tried to interview the victim. Unfortunately, she was not interviewable. It wasn't for lack of trying, though. Her health status prevented that from happening.

We talked to many other residents while we were there, but did we record them as formal interviews? No.

We'd also conducted some concurrent inspections, and there are resident interviews in that that were of a vague nature about how are things sort of in general in the home, yeah.

Q. Okay. Okay. And what about -- did you speak to any family members?

A. We did speak with the family of the victim. It was not done until much later. Almost to the end of the inspection, though, and we actually did not speak with them in the home but on the telephone.

Q. Okay. Can you give us an idea how long you were at Telfer Place and on-site for this inspection?

A. Definitely it was intermittent and sporadic, but the dates from the inspection report go from October the 5th

1 of 2016 until March the 21st of 2017; however,  
2 for the month of January, it appears that we  
3 were only there for one date.

4 Q. Okay. So when you say  
5 "sporadic," you weren't there every single day  
6 during --

7 A. Definitely not, no. We were  
8 working on other inspections as well. And some  
9 of them -- some of them -- some of the time --  
10 and I would have to cross-reference this, but  
11 maybe while we were in the home, we were  
12 working on one of the concurrent inspections  
13 and didn't look at this inspection at all  
14 during that time as well. So that date would  
15 not have been included.

16 Q. Okay. Okay. So I want to  
17 turn to talking about some of the findings from  
18 your inspection. And you'll find your  
19 inspection report at Exhibit F to the  
20 Affidavit.

21 And, Laura, I'd ask you if you  
22 could pull up that report. It's Document  
23 41487.

24 So the first thing I want to ask  
25 you about, it looks like your report comes out  
26 May 24th; is that correct?

27 A. That's what it looks like.

28 Q. So we know from Rhonda and  
29 Natalie's evidence that the  
30 Caressant Care/Meadow Park inspection reports  
31 don't come out until later in August. Is there  
32 any reason why you were able to issue your

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1 report earlier?  
2 A. I was directed that today is  
3 the day it can go.  
4 Q. Okay.  
5 A. So I can't say why theirs  
6 took longer. Definitely the report was --  
7 versions of the report were prepared long  
8 before this date. I was directed to hold off,  
9 though, until one day.  
10 Q. Okay. Okay. Who was it that  
11 directed you that this is the day it can go  
12 today?  
13 A. I received the information  
14 from my manager. Who she received it from, I  
15 couldn't say for sure, though.  
16 Q. Okay. So let's go -- let's  
17 scroll down towards the bottom of page 2,  
18 please.  
19 So this is the summary of the  
20 findings of noncompliance found during this  
21 inspection?  
22 A. That's correct. There were  
23 six written notifications, each of which had a  
24 Voluntary Plan of Correction attached to them.  
25 Q. Okay. So what I want to do  
26 now is go through some of the specific  
27 findings. If we could scroll down to the first  
28 finding which is here. Thank you, Laura.  
29 So this here is a failure to  
30 comply with Section 8 of the Long-Term Care  
31 Homes Act, and this is -- this is the provision  
32 that's sort of colloquially known as the 24/7

1 RN provision?

2 A. That's correct.

3 Q. So if we scroll down to the  
4 next page, these are the findings here. So can  
5 you explain to us why you issued that  
6 particular finding of noncompliance?

7 A. Definitely. So Telfer Place,  
8 as we've learned from interviews conducted by  
9 staff at the facility, is a smaller home. It's  
10 a 45-bed long-term care home.

11 They, because of their home  
12 size, have only one Registered Nurse on usually  
13 24 hours a day, 7 days a week. They have RPNs  
14 on as well, though, in addition to PSWs.

15 However, there were occasions  
16 when, due to a variety of reasons, they were  
17 not able to have an RN who was a member of the  
18 staff at the home, so an employee of Telfer  
19 Place, Revera that was able to come to work,  
20 although the home was able to demonstrate that  
21 they did make efforts to have one of their own  
22 staff.

23 So when these occasions  
24 occurred -- and sometimes they were known about  
25 in advance, and sometimes they happened very  
26 quickly in the spur of the moment -- they  
27 reached out to an agency to try to fill those  
28 shifts.

29 Sometimes they were able to fill  
30 the shifts with a Registered Nurse. Sometimes,  
31 unfortunately, if you go a little bit further  
32 down, it notes that they were not able to fill

12:07:08 1 it with a Registered Nurse, so they brought in  
12:07:10 2 one of their own Registered Practical Nurses to  
12:07:13 3 work with one of the RNs on call.

12:07:16 4 Q. Can you scroll down a little  
12:07:18 5 bit, Laura?

12:07:19 6 A. It's actually on the page. I  
12:07:23 7 see that now. I just -- yeah. Or with an --  
12:07:23 8 yes, so that was one of the two things.

12:07:25 9 So when we spoke with the  
12:07:26 10 Executive Director at the time, he confirmed  
12:07:31 11 that the home was unable to fill the shifts,  
12:07:36 12 that it was not, to the best of his knowledge,  
12:07:40 13 related to a, quote, emergency situation,  
12:07:42 14 emergency as defined in the legislation, and  
12:07:46 15 that they weren't entitled to the exception  
12:07:51 16 and, therefore, were not compliant with 8(3).

12:07:54 17 Q. Okay. And so if we scroll  
12:07:56 18 down, we can see that you issue a VPC --

12:08:01 19 A. That's correct.

12:08:02 20 Q. -- along with this -- with  
12:08:04 21 this written notification of noncompliance.

12:08:07 22 So this was, in fact, when you  
12:08:14 23 assess this according to the Judgment Matrix,  
12:08:18 24 this was the default action that the Judgment  
12:08:20 25 Matrix suggested would be appropriate, a VPC;  
12:08:24 26 is that correct?

12:08:24 27 A. I believe that's correct. I  
12:08:26 28 don't believe we made any variance. In fact, I  
12:08:30 29 know we did not make any variances on this one.

12:08:32 30 Q. Okay. Okay. So we do -- the  
12:08:33 31 voluntary -- or, sorry, your Judgment Matrix is  
12:08:36 32 at Tab G. And I think it would be helpful to

1 pull up.

2 I notice one thing here, we'd  
3 seen with both the Caressant Care and Meadow  
4 Park reports that they would typically include  
5 in their reports what they had noted in terms  
6 of how they were assessing the severity, the  
7 scope, and the compliance issue right there.

8 So we don't see it in your  
9 reports, but that is included in your Judgment  
10 Matrix in this case; correct?

11 A. That's correct.

12 Q. Okay. So let's --

13 A. It's not our practice -- if I  
14 can just -- I'm sorry to interrupt. It's not  
15 our practice to include the statement about  
16 severity, scope, and compliance history in WNs  
17 unless they are attached to a compliance order.

18 And at that time, that would be  
19 included as part of the grounds and not part of  
20 the finding, so that's our practice.

21 Q. Okay. And that's the  
22 practice in the Hamilton Service Area Office;  
23 correct?

24 A. Yes, that is correct.

25 Q. Okay. So if we could pull up  
26 document ID 41509, and this is in your  
27 Affidavit at Tab G.

28 So if we can scroll down to that  
29 first -- the first finding where it says act  
30 8(3), that row.

31 So here's where we can see what  
32 the Judgment Matrix has advised you; is that



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12:11:03  
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1 right? So you've --  
2 A. Yes.  
3 Q. -- assessed the -- the  
4 severity is a 1. And if we scroll -- if you  
5 can just go up a little bit, Laura.  
6 So the severity, if you put it  
7 at a 1, that's a minimum risk?  
8 A. That's correct.  
9 Q. Okay. And the scope here you  
10 set as a 2 showing a pattern. Can you explain  
11 that?  
12 A. Sure. If you look above at  
13 the box beside "severity," it mentions scope's  
14 pattern is greater than 5 percent or fewer than  
15 30 percent of the affected population surveyed.  
16 So in this case -- and I'm so  
17 sorry. I'm not great at math either.  
18 I believe it's approximately 25 shifts.  
19 And the reason why I put  
20 approximately 25 in the document is because  
21 there were a few shifts that they were maybe an  
22 hour without a Registered Nurse in the home,  
23 and then someone was able to come in. So it  
24 was approximately.  
25 Q. Okay.  
26 A. And there was a small  
27 handful. I think it was maybe seven where  
28 there was no RPN in the building. And  
29 I believe we looked at a period of  
30 approximately five months.  
31 So if we look at three shifts  
32 seven days week times that period of time, it

12:11:07 1 would be a pattern. It wouldn't be the other  
12:11:12 2 two options.

12:11:13 3 Q. It sounds like you're better  
12:11:15 4 at math than you think you are.

12:11:17 5 Okay. So let's look at the  
12:11:18 6 compliance history too. So we see here that  
12:11:21 7 you say in terms of compliance history, it says  
12:11:27 8 two. So -- or, sorry --

12:11:28 9 A. I'm sorry. It says three.

12:11:29 10 Q. I'm sorry. So that says they  
12:11:32 11 had one or more related noncompliance than the  
12:11:36 12 last three years.

12:11:37 13 So there had been a previous  
12:11:38 14 finding of noncompliance in relation to this  
12:11:40 15 specific provision of the act?

12:11:41 16 A. There was one previous  
12:11:44 17 finding of noncompliance in relation to this  
12:11:47 18 provision of the act. It's -- it was in  
12:11:49 19 relation to -- do you want me to speak about  
12:11:51 20 this?

12:11:51 21 Q. Sure.

12:11:52 22 A. It was in relation to an  
12:11:53 23 inspection that was conducted and discussed  
12:11:56 24 here previously as well with the former  
12:12:00 25 Executive Director, Dian Shannon, when Dian  
12:12:06 26 assisting an agency RPN because there wasn't an  
12:12:10 27 RN in the building.

12:12:10 28 So that was the identified shift  
12:12:13 29 that was identified previously as -- I'm very  
12:12:19 30 confident to say it was a WN 483.

12:12:24 31 Q. Okay.

12:12:24 32 A. I'm not very confident. I'm

12:12:27 1 highly confident.

12:12:29 2 Q. Okay. Thank you. If we can  
12:12:30 3 go back to that inspection report then, 41487,  
12:12:35 4 and let's move on to the next finding of  
12:12:37 5 noncompliance. And you should find that at  
12:12:42 6 page 4. And at the very bottom, if you can  
12:12:50 7 scroll down there, Laura.

12:12:52 8 So this here is a failure to  
12:12:55 9 comply with Section 75, screening measures. If  
12:12:59 10 we can go on to the next page. Can you explain  
12:13:02 11 to us, Lisa, what that finding was in relation  
12:13:04 12 to?

12:13:04 13 A. If it's okay, I'll just read  
12:13:08 14 it. [AS READ]

12:13:08 15 "The screening measure shall  
12:13:10 16 include criminal reference  
12:13:11 17 checks unless the person being  
12:13:14 18 screened is under 18 years of  
12:13:15 19 age."

12:13:15 20 So what this is that when you hire an employee,  
12:13:21 21 within six months of them accepting employment,  
12:13:26 22 they must have a valid criminal reference check  
12:13:31 23 or police screening of a vulnerable section  
12:13:35 24 screen. So that -- that was the issue, and if  
12:13:38 25 they're greater than 18 years of age, so yeah.

12:13:42 26 Q. And so you had found that  
12:13:43 27 there were a number of RNs who had worked in  
12:13:47 28 the home, and there was not a valid vulnerable  
12:13:50 29 sector check or criminal record check  
12:13:53 30 conducted; correct?

12:13:53 31 A. That is correct, Megan. If I  
12:13:55 32 could just clarify, though. So these were all

1 relation to agency staff that were working at  
2 the home, not regular employees of the home, so  
3 not employees of Telfer Place.

4 So they were employees of an  
5 agency that were brought in to work shifts in  
6 the long-term care home as an employee of the  
7 agency.

8 Q. Okay. And so you say here --  
9 and this is -- when we were talking about the  
10 numbers of employees here.

11 A. Yes. Yes.

12 Q. So RN Number 610, 609, and  
13 605, those were the RNs that had not had --

14 A. RN 610 is EW, yes.

15 Q. Okay. Okay. So that's  
16 Elizabeth Wettlaufer.

17 A. And RN 610, that number is  
18 used for that individual throughout the report,  
19 not just in one finding. We would never change  
20 her number. As we progress, it's always the  
21 same number.

22 Q. Okay.

23 A. Okay?

24 Q. Okay. Thank you. That's  
25 helpful. So we know throughout this report,  
26 RN 610 is Elizabeth Wettlaufer?

27 A. That's correct.

28 Q. She was one of the nurses  
29 that was working in that home, and the home had  
30 not confirmed that she had a criminal record  
31 check completed; is that correct?

32 A. The home did not have, that's

12:15:04 1 correct, a copy of her criminal reference check  
12:15:07 2 on file.

12:15:07 3 Q. All right. So if we can just  
12:15:09 4 scroll down to the next page. So we see that a  
12:15:12 5 VPC was issued in relation to this finding.

12:15:17 6 A. That's correct.

12:15:17 7 Q. And if we could just go back,  
12:15:23 8 then, to your Judgment Matrix. So that's 45109  
12:15:27 9 and Tab G. Oh, sorry, 41509. I think I  
12:15:45 10 misspoke.

12:15:46 11 All right. So let's -- it looks  
12:16:08 12 like this was a case where you have the  
12:16:12 13 severity of risk is a minimum risk?

12:16:14 14 A. That is correct.

12:16:15 15 Q. And can you explain that?

12:16:16 16 A. The home definitely was under  
12:16:20 17 the impression that the agency was collecting  
12:16:24 18 the criminal reference checks.

12:16:26 19 The home was completing criminal  
12:16:29 20 reference checks for their own -- or not  
12:16:31 21 completing. Ensuring that the criminal  
12:16:34 22 reference checks were in place for their own  
12:16:36 23 staff in the home.

12:16:37 24 We felt it was -- I felt it was  
12:16:43 25 a minimum risk based on the fact that the home  
12:16:47 26 was under the impression that that information  
12:16:49 27 was available, was collected, and was desired,  
12:17:00 28 i.e., that they didn't fail the check. I don't  
12:17:02 29 think it's a pass or a fail. It is a pass. It  
12:17:03 30 wasn't a negative check would be probably a  
12:17:06 31 better word.

12:17:06 32 Q. Okay. And were you able to

12:17:08 1 confirm with the agency whether those criminal  
12:17:13 2 record checks had been done?

12:17:13 3 A. To be very honest with you,  
12:17:15 4 repeated attempts were made to speak with the  
12:17:19 5 agency. Unfortunately, we were not able to  
12:17:20 6 talk to them. They declined speaking with us  
12:17:23 7 on a number of -- and when I say "us," that  
12:17:29 8 Lesley, Lesley Edwards who had made those  
12:17:31 9 attempts.

12:17:32 10 Although she would have a  
12:17:32 11 conversation with her, it was to say, "I won't  
12:17:33 12 be speaking with you." There wasn't any other  
12:17:34 13 conversation than that, so yeah.

12:17:35 14 Q. Okay. And that agency who  
12:17:37 15 had placed Elizabeth Wettlaufer in the home, we  
12:17:39 16 heard during the facilities phase, was  
12:17:42 17 Lifeguard?

12:17:43 18 A. That is correct. And we had  
12:17:44 19 made attempts to speak with Heidi.

12:17:46 20 Q. Okay. So you set it as a  
12:17:49 21 minimum risk. And then in terms of the scope  
12:17:52 22 of the problem, we see -- you've set that as a  
12:17:56 23 3, so that's widespread?

12:17:58 24 A. I did. And the reason for  
12:17:59 25 that was that we looked at three agency staff.  
12:18:02 26 We did not include in our sample any staff of  
12:18:06 27 the home. We were looking specifically at 3  
12:18:10 28 agency staff. Sorry about that.

12:18:12 29 Q. Okay. And so all three of  
12:18:13 30 those had not had the criminal record check,  
12:18:15 31 and so --

12:18:16 32 A. That's correct.

1 Q. -- that essentially is what  
2 gets you to this being a widespread problem?

3 A. Yeah. Three of three.

4 Q. In terms of the compliance  
5 history, here it's a 2. So explain to us what  
6 the 2 means.

7 A. The home had one or more  
8 unrelated noncompliance in the past three  
9 years. In other words, they had noncompliance  
10 on the file in the past 36 months. And they  
11 did.

12 Q. But not a finding of  
13 noncompliance in relation to this particular  
14 provision?

15 A. No. That's correct.

16 Q. Okay. So we see here that  
17 the Judgment Matrix actually suggests that the  
18 default action should have been a compliance  
19 order?

20 A. Correct. A level C, a CO.

21 Q. Okay. And so ultimately, you  
22 decide to issue this as a Voluntary Plan of  
23 Correction?

24 A. I did.

25 Q. Explain that to us.

26 A. I'll read what I wrote, if  
27 that's okay. The change to produce -- or there  
28 was a change. We reduced it to a VPC as it was  
29 agency staff -- as the agency who employed the  
30 staff were to have completed the required  
31 screening. The home did not verify that this  
32 had not had been -- had not been completed, but

1 it was the expectation.

2 I guess I'm pretty good at math  
3 but not really good at reading today.

4 Basically the issue came down to  
5 the fact that the home was aware of their  
6 responsibility. The home was conduct -- for  
7 their own staff, the home was conducting it,  
8 but they were under the impression that based  
9 on the relationship that they had with the  
10 agency, that this was being done on their  
11 behalf.

12 So from that regard, the  
13 decision was made to move it from a compliance  
14 order to a Voluntary Plan of Correction.

15 Q. Okay. Is there anything  
16 under the legislation that would require the  
17 employment agency, that would have required  
18 Lifeguard to complete those criminal record  
19 checks?

20 A. Our legislation is  
21 relation -- is pertinent to the long-term care  
22 home, not to the agency. So to my knowledge,  
23 no. Any agency isn't required to follow our  
24 legislation. They're required to -- that's for  
25 the long-term care home.

26 Q. Okay. And was there some  
27 sort of contract or some sort of agreement  
28 between Lifeguard and Telfer Place in relation  
29 to the employment of the agency RNs in the  
30 home?

31 A. There was a contract. I will  
32 admit it was a very vague and small contract.



1 Did it specifically make mention related to  
2 criminal reference checks? No, but that was  
3 definitely the understanding of the individuals  
4 that we spoke with, that that was part of what  
5 was included in what they were getting.

6 Q. And was there any recognition  
7 on the part of the home that this needed to  
8 change?

9 A. Oh, definitely. Once the  
10 question was asked, although we didn't give  
11 direction or advice, there was a lightbulb  
12 moment. And right away that was put into  
13 place.

14 Q. Okay. Okay. So the next  
15 finding that I want to deal with is on page 6  
16 back in the report. So let's just scroll down  
17 here. So this is a finding of noncompliance in  
18 relation to the --

19 A. Can I retract my last  
20 statement?

21 Q. Sure.

22 A. I'm going to try to recall  
23 now, and I can't. It might have been that the  
24 home, during us asking for these documents, had  
25 figured it out just before then as well  
26 regardless -- it was the course of this  
27 inspection that they had identified that they  
28 should have had these checks completed for  
29 these individuals as well.

30 So whether we asked the question  
31 first or if they came to it themselves during  
32 us just looking at other things, I'm not a

1 hundred percent sure at this time.

2 Q. Okay. But there was a  
3 recognition in --

4 A. Definitely. Definitely.

5 Q. Okay. Okay. So let's deal  
6 with this finding of noncompliance. So this  
7 was in relation to training.

8 Can you explain -- we haven't  
9 actually spoken about this provision that much,  
10 but can you explain what is required of the  
11 licensee of a long-term care home with respect  
12 to training?

13 A. Sure. You picked a long one.

14 [AS READ]:

15 "The licensee shall ensure that  
16 all staff in the home have  
17 received training as required by  
18 this section."

19 And then there's several sections that go on  
20 down here, and I'll just summarize them.  
21 There's the Bill of Rights, the mission  
22 statement, the home's policy to promote zero  
23 tolerance of abuse and neglect of residents,  
24 the duties under Section 24 to make mandatory  
25 reports, the protections afforded by Section  
26 26, which is whistle-blowing protections, the  
27 long-term care homes policy for the minimizing  
28 of restraining of residents, fire safety and  
29 fire prevention, emergency and evacuation  
30 procedures, infection prevention and control,  
31 any other acts, regulations, policies of the  
32 Ministry or similar documents including

12:23:13 1 policies of the licensee that are relevant to  
12:23:15 2 this person's responsibilities and basically  
12:23:17 3 anything else that's in the regulations.

12:23:19 4 Q. Okay. So you find there's  
12:23:24 5 noncompliance in relation to this. If we go to  
12:23:25 6 the next page, the reasons for that are here.  
12:23:28 7 But can you just explain to us what you had  
12:23:33 8 found in the home?

12:23:34 9 A. Sure. So we had -- so we  
12:23:36 10 identified agency staff. And I'm just going to  
12:23:40 11 double-check. They were not the same three,  
12:23:45 12 and I'm not quite sure why. But that's okay.  
12:23:48 13 Maybe they were...

12:23:49 14 One of them being employee 610,  
12:23:53 15 which was Elizabeth Wettlaufer. We had asked  
12:23:55 16 for their training records. The home was  
12:23:59 17 honest and did not maintain employee records of  
12:24:03 18 individuals that were not employees of the  
12:24:05 19 home, so there was not an employee file of  
12:24:08 20 Elizabeth Wettlaufer or the other agency staff  
12:24:10 21 that we looked at; however, they had training  
12:24:13 22 records and files, so were able to provide the  
12:24:16 23 records.

12:24:22 24 The home used a checklist of  
12:24:24 25 sorts, and when the agency staff was to come  
12:24:28 26 prior to their first shift or ideally before  
12:24:31 27 their first shift or if it was a short-notice  
12:24:35 28 sort of situation, they would ask them to come  
12:24:37 29 in approximately four hours before their shift.  
12:24:39 30 And they would have one of the staff complete  
12:24:41 31 the checklist with them.

12:24:43 32 We reviewed the checklist. The

1 checklist had identified a whole bunch of  
2 things in addition to what was required. They  
3 also had other things that they felt were  
4 important that they were training them on.

5 And the checklist that we  
6 reviewed for these two individuals did not  
7 identify that everything was indeed completed.

8 We interviewed the staff member  
9 who provided training to EW. She verified it  
10 was her signature and EW's signature on the  
11 form and that there were blanks on the form,  
12 that she couldn't recall the orientation at all  
13 being that it was in 2015, and we were speaking  
14 to her approximately two years later.

15 But she verified that to her  
16 knowledge, it wasn't completed, and she wasn't  
17 aware of any other information that would have  
18 been received.

19 So we then went on to the second  
20 RN, who was RN Number 609, further down on the  
21 page. And this employee had started as an  
22 agency individual in the home earlier, a little  
23 bit earlier in May.

24 During the course of reviewing  
25 this one, though, it was identified that  
26 sometime in the summer of 2016, which was  
27 August, she had received retraining and, in  
28 fact, training in all of the required areas.

29 So the home had identified  
30 through their own internal processes prior to  
31 being aware of any offences of Elizabeth  
32 Wettlaufer, those even outside of Telfer Place,

12:26:16 1 that there was a little blip in their system,  
12:26:19 2 and they had put a plan in place to address  
12:26:22 3 that which included retraining of all agency  
12:26:25 4 and making sure that all future agency had this  
12:26:28 5 information.

12:26:28 6 So RN Number 6 did indeed work  
12:26:31 7 without full orientation from May 2014 until  
12:26:35 8 August 2016, but was provided the training  
12:26:39 9 then.

12:26:39 10 And the third agency staff that  
12:26:40 11 we looked at is not identified on this report,  
12:26:43 12 and that's because that individual was fully  
12:26:46 13 trained.

12:26:47 14 Q. Okay. So if we scroll down,  
12:26:48 15 we can see that this is issued as well with a  
12:26:53 16 Voluntary Plan of Correction.

12:26:53 17 A. It is.

12:26:54 18 Q. Let's very quickly toggle  
12:26:56 19 back to the Judgment Matrix.

12:26:57 20 A. I was anticipating that.

12:26:59 21 Q. And here we see -- if we go  
12:27:07 22 down to -- if we can scroll down so we can see  
12:27:11 23 training and orientation.

12:27:12 24 We see the severity here is 2,  
12:27:14 25 minimal harm or potential for actual harm. So  
12:27:18 26 why is this set as a level 2?

12:27:22 27 A. If someone doesn't -- if  
12:27:24 28 someone who is in charge of and responsible for  
12:27:26 29 the home doesn't have training on some of these  
12:27:30 30 things and having to make decisions on  
12:27:33 31 restraints, fire, abuse, things like that,  
12:27:37 32 doesn't have the knowledge as to what they

12:27:39 1 should do in that situation and they are the  
12:27:41 2 person responsible for the home, that that's a  
12:27:44 3 potential. That's a --

12:27:47 4 Q. A potential for actual harm  
12:27:49 5 is what you're saying?

12:27:50 6 A. Yeah.

12:27:51 7 Q. Okay.

12:27:51 8 A. There was two -- oh, I should  
12:27:53 9 let you do this, sorry.

12:27:54 10 Q. No, you can go ahead.

12:27:55 11 A. Sorry. There was two of  
12:27:58 12 three of the staff that we looked at impacted,  
12:27:59 13 so our scope would be patterned, and  
12:28:02 14 acknowledging that the second staff member  
12:28:04 15 wasn't impacted for the entire time.

12:28:06 16 She had received indeed training  
12:28:08 17 prior to our revival and prior to knowledge of  
12:28:12 18 Elizabeth Wettlaufer. And there was a level 2  
12:28:17 19 there in relation to --

12:28:21 20 Q. The compliance history?

12:28:23 21 A. Correct, one or more  
12:28:26 22 unrelated noncompliances in the past.

12:28:26 23 Q. In the previous 36 months, no  
12:28:29 24 finding of noncompliance in relation to this  
12:28:32 25 specific section?

12:28:33 26 A. To 76.

12:28:34 27 Q. Okay. So we do see the  
12:28:35 28 Judgment Matrix default here was the compliance  
12:28:38 29 order?

12:28:38 30 A. That's correct.

12:28:38 31 Q. Can you explain to us why you  
12:28:40 32 chose to vary that and issue a VPC instead of

12:28:44 1 the compliance order?

12:28:44 2 A. Very similar to some of the  
12:28:46 3 reasons that were previously given by Natalie.  
12:28:48 4 The home had already identified the problem and  
12:28:50 5 had corrected the problem, so it wasn't a  
12:28:52 6 current problem in the home. We were able to  
12:28:54 7 identify that based an employee number 3 that  
12:28:56 8 we looked at and employee number 2.

12:28:57 9 So the home had, on their own,  
12:29:00 10 identified the concern and put a plan in place  
12:29:02 11 to address it, and we were able to verify that  
12:29:05 12 the plan was indeed carried through, and the  
12:29:08 13 training was provided.

12:29:09 14 Q. Okay. Okay. Thank you. So  
12:29:12 15 let's go back to the report. Thank you, Laura.

12:29:18 16 And if we could go to page 8 and  
12:29:22 17 scroll down a little bit further in page 8.  
12:29:25 18 We'll see the next finding of noncompliance.  
12:29:29 19 So that's in relation to Section 101 of the act  
12:29:35 20 dealing with complaints. And I believe we've  
12:29:38 21 seen this as well in the Meadow Park  
12:29:40 22 inspection.

12:29:41 23 A. I believe we did as well  
12:29:43 24 yesterday.

12:29:43 25 Q. So explain to us this  
12:29:47 26 particular -- what the issue was that you had  
12:29:50 27 found at Telfer Place in relation to how the  
12:29:53 28 home was dealing with complaints.

12:29:55 29 A. So admittedly, the reporting  
12:29:58 30 and complaints IP was not done by myself. It  
12:30:02 31 was done by Lesley.

12:30:03 32 Q. Okay.

1 A. However, Lesley was able to  
2 identify that the home failed to document --  
3 failed to ensure a documents record was  
4 maintained in the home that included the date  
5 that the complaint was received, the type of  
6 action taken to resolve the complaint, the date  
7 of the action, time frame for action to be  
8 taken, any follow-up reaction, the follow-up  
9 resolution, the date on which any response was  
10 provided to the complainant and a description  
11 of that response to the complainant and made in  
12 turn, as well as that the licensee failed to  
13 ensure that documented complaints were  
14 received -- I'm sorry. Were reviewed and  
15 analyzed for trends at least quarterly.

16 So there's actually the two that  
17 are included into the one finding of  
18 noncompliance.

19 Q. Okay. So there were two  
20 specific problems identified?

21 A. That's correct.

22 Q. So can we -- I'm sorry. I  
23 have you really working a lot this morning,  
24 Laura. Let's go back to -- well, so we know  
25 this was issued with a Voluntary Plan of  
26 Correction?

27 A. That's correct.

28 Q. Okay. So let's go back to  
29 the Judgment Matrix.

30 A. Judgment Matrix.

31 Q. So we see here dealing with  
32 complaints, it says here minimum risk. Why



1 would this be set as a minimum risk, the level  
2 1?

3 A. I believe based on the  
4 information that Lesley had collected, that it  
5 wasn't that they weren't dealing with them. It  
6 was that they -- their documentation was strong  
7 in relation to the actions that they had taken  
8 and when and things like that.

9 Q. Okay.

10 A. The scope was two, although  
11 there was three, I believe, identified in the  
12 report, A, B, and C.

13 Lesley did look at more than  
14 three complaints. So if we do the math, it  
15 would have probably fallen in that, between 5  
16 and 33 percent.

17 Q. Okay.

18 A. And in relation to the  
19 compliance history, it was a level 3, so there  
20 was one or more related noncompliances in the  
21 past three years.

22 Q. Okay. But the default action  
23 was the Voluntary Plan of Correction, not a  
24 compliance order; correct?

25 A. That's what that shows, yeah.

26 Q. Okay.

27 A. Yeah.

28 Q. Okay. So then let's also --  
29 let's go back to the report again. We only  
30 have two other findings to go through. But on  
31 page 11 -- let's jump down to there.

32 So this is -- we're all getting

1 familiar with this section --

2 A. 135.

3 Q. -- of the regulation, 135.

4 So this is -- can you tell us  
5 specifically what the issues were in relation  
6 to medication incidents?

7 A. Sure. I can give you the  
8 Coles Notes version here. So basically, the  
9 concern that was identified here by Lesley was  
10 that every medication incident was not reported  
11 to the SDM of the resident, the substitute  
12 decision maker, sorry, as well as the pharmacy  
13 service provider.

14 Lesley looked at a number of  
15 medication incidents, and she had identified  
16 five that that information was not documented,  
17 both the communication to the resident  
18 substitute decision maker as well as the  
19 pharmacist, or pharmacy service provider.

20 Q. Can we just scroll down a  
21 little bit.

22 A. Yeah.

23 Q. So were all five of those  
24 medication incidents -- did all five of those  
25 take place on the same date?

26 A. They did apparently. So they  
27 were all errors of omission, which means that  
28 for whatever reason, a drug was not  
29 administered to the resident at the time that  
30 it was prescribed.

31 Q. Okay. And so we know there  
32 are only 35 residents at --

12:33:59 1 A. 45 residents at Telfer Place.

12:34:01 2 Q. My apologies. So five  
12:34:05 3 medication incidents on one day in a home with  
12:34:09 4 45 residents, is that a high number of  
12:34:12 5 medication incidents for one day?

12:34:14 6 A. I have to -- although I've  
12:34:16 7 not discussed this with Lesley, I would have to  
12:34:20 8 believe that that might be why she used these  
12:34:23 9 as the example that she chose to use.

12:34:25 10 Q. Okay. Was there any thinking  
12:34:28 11 about also issuing a finding of noncompliance  
12:34:30 12 in relation to failure to provide medication --

12:34:34 13 A. 131.

12:34:36 14 Q. Yes, 131.

12:34:37 15 A. Yeah. At the time, was  
12:34:41 16 there? No. The reason being Lesley and  
12:34:45 17 Phyllis had observed a number of medication  
12:34:49 18 passes. There were no concerns with residents  
12:34:53 19 not receiving medications as prescribed at that  
12:34:55 20 time.

12:34:57 21 We also indeed, like my  
12:35:00 22 colleagues, were requested to do all of the  
12:35:03 23 medication IP.

12:35:06 24 We were under the impression  
12:35:07 25 that we were looking to see if there was  
12:35:09 26 processes and systems in place. So by all  
12:35:13 27 means, my practice is at this time and  
12:35:17 28 continues to be, although now it's enhanced a  
12:35:20 29 little bit, if I observe a medication error, of  
12:35:22 30 course I'm going to further inspect upon it and  
12:35:25 31 identify it as noncompli -- wherever it might  
12:35:27 32 be appropriate, whether it be 131 or 131(2).

12:35:31 1 Nor were we given a specific  
12:35:34 2 intake to look at a specific medication  
12:35:37 3 incident. And for that reason, I believe the  
12:35:39 4 decision was not made to issue under 131.

12:35:42 5 Q. Okay. Okay. So let's -- we  
12:35:46 6 know this is issued with a Voluntary Plan of  
12:35:48 7 Correction?

12:35:48 8 A. That's correct.

12:35:49 9 Q. Let's quickly go back again  
12:35:52 10 to that Judgment Matrix.

12:35:53 11 A. Yeah.

12:35:53 12 Q. And let's look at how this is  
12:36:02 13 completed. So the severity here is minimum  
12:36:04 14 risk?

12:36:04 15 A. That's correct. So Lesley  
12:36:06 16 not only looked at the medication incident  
12:36:09 17 reports but into the clinical records of those  
12:36:12 18 individuals, those residents that were impacted  
12:36:15 19 by these errors on that identified date and  
12:36:17 20 identified that there was no negative outcome  
12:36:20 21 to those -- to those residents.

12:36:22 22 It was identified that the  
12:36:24 23 pharmacy did receive the incident reports but  
12:36:27 24 at a later date, whether it be at one of their  
12:36:30 25 quarterly meetings or during a tracking,  
12:36:35 26 sharing of a tracking tool, something to that  
12:36:38 27 effect.

12:36:38 28 But the determination was that  
12:36:39 29 basically -- just that it was a failure to  
12:36:42 30 document that information, didn't necessarily  
12:36:47 31 put the resident at risk. It -- the physician  
12:36:52 32 was aware, things like that. So that was how

1 that decision was made.

2 Any more questions about that?

3 Q. Well, talk to us about the  
4 scope and --

5 A. Sure. So, again, Lesley  
6 looked at more than these. There was other  
7 incidents that she looked at as well. And for  
8 that reason, I believe that had fallen under  
9 that place in the category, and as well, one or  
10 more related noncompliances in the past three  
11 years. So there was previous noncompliance in  
12 relation to medications in the past three  
13 years.

14 Q. Okay. The default action,  
15 despite the previous history, was the Voluntary  
16 Plan of Correction?

17 A. Yes.

18 Q. Okay. Okay. So then let's  
19 go back to the inspection report, and let's  
20 look at the final finding of noncompliance. So  
21 this is on page 12, and this is in relation to  
22 Section 234 of the regulation. So this is also  
23 one we haven't seen previously. What's  
24 required by Section 234?

25 A. Well, this was one that was  
26 new to me as well. I hadn't issued it prior to  
27 this inspection.

28 Q. Okay.

29 A. So this one identifies that  
30 the home is required to keep a record of each  
31 staff member that includes at least the  
32 following, which would be where applicable,

12:38:29 1 verification of the staff member's current  
12:38:31 2 certificate of registration with the College,  
12:38:34 3 which would be the College of Nurses in this  
12:38:34 4 case that we were looking at of the regulated  
12:38:38 5 health profession to which he or she is a  
12:38:39 6 member or verification of that staff member's  
12:38:42 7 current registration with the regulatory body  
12:38:44 8 governing his or her profession.

12:38:46 9 So the home was required to  
12:38:47 10 maintain a record of that individual's  
12:38:49 11 certificate of competence or some other proof  
12:38:53 12 of that. That's what's required of that.

12:38:56 13 Q. Okay. Okay. And so what had  
12:38:59 14 you found in the home that led to the finding  
12:39:01 15 of noncompliance in relation to this? Maybe if  
12:39:05 16 you scroll down to the next page too. You can  
12:39:06 17 give us your version of events, if you'd like.

12:39:09 18 A. So the Coles Notes version  
12:39:11 19 again is basically we had asked for did the  
12:39:15 20 home maintain records of the agency staff in  
12:39:21 21 relation to their certificate of competence.

12:39:25 22 It was identified as well that  
12:39:26 23 the home had communicated that their agreement  
12:39:31 24 with the agency that provided these staff would  
12:39:35 25 ensure that the staff member was a member of  
12:39:37 26 good standing with the CNO, the College of  
12:39:40 27 Nurses.

12:39:42 28 They had identified that they  
12:39:43 29 did not verify this. They did not have a  
12:39:49 30 record of it for the two staff identified.

12:39:53 31 However, when I went on the  
12:39:55 32 website myself to find a nurse, with the

12:39:59 1 exception of 610, the registrants were indeed  
12:40:03 2 registrants in good standing with the College.

12:40:09 3 And so it wasn't that they were  
12:40:12 4 not registered staff that had come into the  
12:40:15 5 home working as a registered staff member. It  
12:40:18 6 was that they were registered staff, but the  
12:40:20 7 home did not have records of this.

12:40:22 8 Q. Okay. Okay. So let's scroll  
12:40:26 9 down to the bottom there. And, again, we'll  
12:40:33 10 see -- so the VPC is issued in relation to  
12:40:36 11 this?

12:40:37 12 A. Yeah.

12:40:37 13 Q. We'll just one last time  
12:40:40 14 toggle back to the Judgment Matrix. If you can  
12:40:42 15 explain to us the severity scope compliance.

12:40:48 16 A. So we'll look at a severity  
12:40:50 17 of a level 1. Again, I felt it was minimal.  
12:40:53 18 These people were indeed registrants of the  
12:40:56 19 College at the time that they were working in  
12:40:58 20 the home.

12:40:58 21 We looked at three employees.  
12:41:00 22 One of them they didn't have anything for. The  
12:41:03 23 second example, very much like the example in  
12:41:05 24 training, the home had verified current status  
12:41:11 25 with the College on August the 22nd, 2016.

12:41:15 26 This was prior to any knowledge  
12:41:17 27 of Elizabeth Wettlaufer and at that time  
12:41:18 28 maintained documentation to support that the  
12:41:22 29 registrant was entitled to practice with no  
12:41:26 30 restrictions. So they indeed had the records  
12:41:30 31 for that one.

12:41:31 32 So for that reason, we felt it

12:41:34 1 was minimum risk, that they were not un -- that  
12:41:37 2 they were indeed registrants. They just didn't  
12:41:41 3 have the paperwork.

12:41:43 4 We identified as the scope in  
12:41:44 5 that there was two of three -- I'm sorry, two  
12:41:46 6 of three registered staff, and there was one or  
12:41:49 7 more unrelated noncompliance in the past three  
12:41:52 8 years, hence they had noncompliance in some  
12:41:56 9 area in the past 36 months.

12:41:58 10 Q. Okay. And so the default  
12:41:59 11 action, again, was the Voluntary Plan of  
12:42:02 12 Correction?

12:42:02 13 A. It populated as a B, as in  
12:42:04 14 Bob, for a VPC. That's correct.

12:42:06 15 Q. Okay. So that essentially --  
12:42:10 16 those were all your findings?

12:42:12 17 A. That is.

12:42:13 18 Q. There were no noncompliance  
12:42:15 19 orders issued?

12:42:15 20 A. That's correct.

12:42:16 21 Q. There was no follow-up  
12:42:17 22 inspection that's required in relation to this?

12:42:18 23 A. In relation to this  
12:42:19 24 inspection report, that's correct.

12:42:20 25 Q. Okay. So I'm going to move  
12:42:24 26 on, then, to just asking you to reflect a  
12:42:27 27 little bit on the inspection process and the  
12:42:33 28 system in place.

12:42:34 29 So based on -- you've now got 18  
12:42:36 30 years' experience working as an inspector --  
12:42:40 31 you've been -- well, as a compliance advisor  
12:42:41 32 and then an inspector, and you've been an



12:42:44 1 inspector since this new regime came into  
12:42:47 2 effect.

12:42:48 3 Can you tell us if you think  
12:42:50 4 there are any mechanisms within the Long-Term  
12:42:52 5 Care Homes Act and the current inspection  
12:42:54 6 regime that can alert the Ministry to serious  
12:42:56 7 issues in long-term care homes?

12:42:58 8 A. I feel that there are  
12:43:02 9 mechanisms in place, and I think my colleagues  
12:43:05 10 have shared them already. I don't know that I  
12:43:07 11 have anything new to add.

12:43:08 12 But looking at, you know, the  
12:43:09 13 RQI process, looking at the fact that there's  
12:43:13 14 the info line that we take complaints, that  
12:43:18 15 there's critical incidents, that there's  
12:43:18 16 mandatory reporting, that there's those  
12:43:22 17 processes and systems in place is where as well  
12:43:23 18 I would feel that there are mechanisms in place  
12:43:28 19 to identify concerns.

12:43:30 20 Q. And do you think there's an  
12:43:33 21 ability within the current system to detect  
12:43:36 22 those health care workers who would  
12:43:39 23 intentionally harm residents?

12:43:41 24 A. I wish. Short of seeing the  
12:43:48 25 error or short of someone reporting it to me,  
12:43:51 26 it would be quite difficult for me to go there.

12:43:54 27 By all means, I have witnessed  
12:43:56 28 medication errors while I was in the home.  
12:43:58 29 Fortunately, they were not errors of  
12:44:00 30 significance. Someone received two Tylenols  
12:44:03 31 instead of one or something to that effect.

12:44:09 32 But this -- what you're talking

12:44:11 1 about isn't the case of someone making a  
12:44:13 2 mistake or even an error in judgment. This is  
12:44:19 3 someone making a terrible decision, and the  
12:44:24 4 desire is a terrible outcome, so yeah.

12:44:26 5 Q. Okay. So, Lisa, my last  
12:44:29 6 question is if you want to just let us know how  
12:44:33 7 you've been personally impacted by learning  
12:44:36 8 about Elizabeth Wettlaufer's offences.

12:44:39 9 A. I didn't really want this  
12:44:41 10 question. I feel that giving me the  
12:44:49 11 opportunity to answer the question isn't fair  
12:44:52 12 to those who have lost so much and been  
12:44:54 13 impacted so much greater than myself, meaning  
12:45:00 14 the victims and their families. However, I am  
12:45:02 15 given the opportunity.

12:45:05 16 It has impacted me personally,  
12:45:16 17 physically, socially. It's impacted how I feel  
12:45:20 18 I'm perceived by others when I go into a  
12:45:24 19 long-term care home, although admittedly, I  
12:45:28 20 feel that that has worn off quite a bit now.

12:45:31 21 I think it has impacted how  
12:45:34 22 people look in general at nurses, how people  
12:45:37 23 look in general at long-term care homes.

12:45:38 24 I've never once met anyone who  
12:45:41 25 said, "I can't wait to grow old and move into  
12:45:43 26 long-term care." And now it's just been made  
12:45:46 27 that much worse.

12:45:48 28 She did these actions to a  
12:45:51 29 population that is most vulnerable, and she was  
12:45:56 30 in a position of power and chose to abuse that  
12:46:01 31 power, and she didn't have a right to do that.

12:46:07 32 Q. Okay. Thank you, Lisa.

12:46:09 1 A. Thank you.

12:46:10 2 MS. STEPHENS: Those are all my

12:46:11 3 questions.

12:46:21 4 MR. KLOEZE: Commissioner, I

12:46:27 5 have no questions in chief.

12:46:30 6 Thank you.

12:46:30 7 THE COMMISSIONER: Thank you

12:46:31 8 very much.

12:46:37 9 MS. MCALEER: Good morning,

12:46:43 10 Commissioner.

12:46:44 11 THE COMMISSIONER: Good morning.

12:46:46 12 CROSS-EXAMINATION BY MS. MCALEER:

12:46:46 13 Q. Good morning, Lisa.

12:46:46 14 A. Good morning.

12:46:46 15 Q. My name is Jennifer McAleer,

12:46:48 16 and I'm the counsel for Telfer Place, and

12:46:50 17 you'll be happy to hear that I will also be

12:46:53 18 very brief with you this morning.

12:46:55 19 First of all, I just want to ask

12:46:57 20 you a couple of questions of clarification.

12:46:59 21 The Hamilton catchment area, how many long-term

12:47:03 22 homes are actually in that catchment area?

12:47:05 23 A. So I'm not sure if you're

12:47:08 24 aware or not. We've recently added two

12:47:11 25 additional service area offices to the

12:47:14 26 province. Previously, we were Haldimand,

12:47:16 27 Norfolk, Brant, Niagara, Hamilton, and homes in

12:47:16 28 Mississauga.

12:47:19 29 We no longer have many of those

12:47:24 30 Mississauga homes. I'm guessing around 120 or

12:47:27 31 more than that. I'm sorry. I don't really

12:47:30 32 know right now.

12:47:31 1 Q. That's okay. I'm just  
12:47:32 2 looking for a rough number.

12:47:33 3 So I understand that previously  
12:47:34 4 as a compliance advisor, you would have been  
12:47:39 5 assigned, as you said, to 12 or 15 homes?

12:47:41 6 A. That's correct.

12:47:42 7 Q. Do I take it now that under  
12:47:45 8 the current system, you may be called upon to  
12:47:48 9 inspect any one of these 120 plus homes?

12:47:49 10 A. Any -- that is correct. So  
12:47:52 11 previously, I was assigned a geographical area.  
12:47:57 12 At the time that I started, it was a smaller  
12:47:59 13 area. It was only Haldimand, Norfolk, Brant,  
12:48:02 14 Niagara, and Hamilton. We had five advisors at  
12:48:04 15 that time.

12:48:05 16 Now -- and although I could  
12:48:09 17 definitely go with a colleague to another home  
12:48:11 18 or if someone was on vacation, go visit their  
12:48:13 19 home. But now I am required to potentially go  
12:48:17 20 to any home.

12:48:18 21 As well as there's times in the  
12:48:20 22 province where they need additional supports  
12:48:23 23 for whatever reason. Maybe they were  
12:48:25 24 short-staffed or maybe they have a contentious  
12:48:30 25 inspection or something that I may be called  
12:48:32 26 upon to go outside of the Hamilton Service Area  
12:48:35 27 Office.

12:48:35 28 I've done inspections in the  
12:48:36 29 North; I've done inspections for London; I've  
12:48:37 30 done inspections in Toronto and Newmarket all  
12:48:41 31 while working out of the Hamilton office.

12:48:43 32 Q. All right. And I also

12:48:45 1 understood from your Affidavit that there are  
12:48:48 2 currently approximately 35 inspectors in the  
12:48:52 3 Hamilton area. And I got to that number by  
12:48:54 4 looking at paragraph 7 --

12:48:56 5 A. I believe it's 18 and 17.

12:48:57 6 Q. -- where there had been 18  
12:48:59 7 and then there were 17 additional, so now we're  
12:49:01 8 at 35 approximately?

12:49:03 9 A. If your math is correct, I'll  
12:49:05 10 agree.

12:49:05 11 Q. Okay. I'm pretty solid on 17  
12:49:09 12 plus 18.

12:49:09 13 A. Very good.

12:49:13 14 Q. All right. So you have those  
12:49:14 15 35 inspectors who are responsible for 120 plus  
12:49:15 16 homes who may also be called upon to go outside  
12:49:19 17 of that region and do inspections in other  
12:49:20 18 areas as well?

12:49:21 19 A. That's correct.

12:49:21 20 Q. And when you had been a  
12:49:23 21 compliance advisor and you were assigned to  
12:49:29 22 specific homes, 12 to 15, were you the only  
12:49:33 23 person assigned to those 12 to 15, or would  
12:49:35 24 there have been a team of you that were  
12:49:37 25 assigned to those homes?

12:49:38 26 A. So I should clarify. I'd  
12:49:39 27 indicated when I came that there was five  
12:49:41 28 compliance advisors. That would be five  
12:49:44 29 nursing advisors.

12:49:45 30 We also had an environmental  
12:49:47 31 health advisor the whole time I've been in the  
12:49:50 32 office and tried to always have a dietary

12:49:55 1 advisor as well.

12:49:56 2 Sometimes we had two, and  
12:49:57 3 sometimes we had none. Sometimes we had one.  
12:50:00 4 It was a position that was, for whatever  
12:50:03 5 reason, a little bit more difficult to fill.  
12:50:06 6 So I have no idea why I told you that.

12:50:07 7 Q. That's okay. I'll remind you  
12:50:10 8 of my question if that helps.

12:50:10 9 A. Yeah. I'm so sorry.

12:50:11 10 Q. The question was you  
12:50:12 11 indicated you were specifically assigned to  
12:50:14 12 these 12 to 15 homes?

12:50:19 13 A. That's correct.

12:50:20 14 Q. Were you the only person, or  
12:50:20 15 would there have been other compliance advisors  
12:50:20 16 within your office that were also responsible  
12:50:22 17 for those --

12:50:22 18 A. So there were two of us that  
12:50:24 19 were assigned to Hamilton, and a lot of times,  
12:50:29 20 we worked together to complete annual reviews,  
12:50:32 21 not usually complaints, but I was very familiar  
12:50:33 22 with her homes as well as she with mine.

12:50:33 23 So technically, they were my  
12:50:38 24 homes, my responsibility, but we would share if  
12:50:43 25 one of us had a more difficult caseload because  
12:50:47 26 there was more complaints or it was a larger  
12:50:49 27 home, and we wanted to get done in a more  
12:50:53 28 timely fashion, things like that.

12:50:55 29 So technically, I was  
12:50:56 30 responsible for that group of homes, but  
12:50:58 31 definitely the two of us worked together.

12:51:00 32 Q. All right. And, again, I

1 understand you were a compliance advisor for  
2 ten years, and you've been an inspector now for  
3 eight?

4 A. That is correct.

5 Q. And you talked a little bit  
6 about the types of questions and the types  
7 of -- the kinds of advice you provided when you  
8 were a compliance advisor, that ten years as a  
9 compliance advisor.

10 And would it be fair to say that  
11 when you went into a particular home, that the  
12 staff of the home felt comfortable raising  
13 these issues with you or questions with you and  
14 were looking for some guidance from you?

15 A. Yes. I feel, though, that  
16 staff in the home today also feel comfortable  
17 talking to me and sharing information with me.

18 Q. All right. Well, let me ask  
19 you a little bit about that, because there's a  
20 difference between sharing information with you  
21 and then getting information --

22 A. Correct.

23 Q. -- from you.

24 So as I understood it and as I  
25 understood it from listening to some of the  
26 prior witnesses, that as a compliance advisor,  
27 you had more freedom to provide guidance or  
28 advice to the homes, and that as an inspector,  
29 you don't really have as much freedom anymore  
30 to do that?

31 A. I had a great deal of  
32 autonomy previously. That's correct.

1 Q. And not as much now; is that  
2 correct?

3 A. That's no longer my role.  
4 That's correct.

5 Q. All right. And when you did  
6 play that role, did you feel comfortable giving  
7 that advice when asked?

8 A. I was much younger then,  
9 maybe more naive as well. So, yeah, sure, I  
10 felt comfortable. To be honest, though, I  
11 don't know that it was always the best advice  
12 that I had given.

13 Sometimes I was very wise and  
14 would say, "I'm sorry. I really don't know, or  
15 maybe you need to go talk to" -- I can think of  
16 an example of dietary where I -- they had asked  
17 me a question, something so simple as about  
18 hydration. I said, "Oh, I really don't know."  
19 So I referred them to our dietary staff.

20 But there definitely could have  
21 been occasions where I might have -- did not  
22 extend best practice advice, not on purpose for  
23 sure.

24 Q. All right. And did you feel  
25 at any point in time that hearing those  
26 questions and providing that advice or handing  
27 out the best policies in that folder you had  
28 collected over the years, did that in any way  
29 compromise your ability to determine whether or  
30 not a home had, in fact, failed to meet the  
31 standards and criteria of the program manual as  
32 it then was?



1 A. Personally, that's -- no, I  
2 don't feel it did.

3 Q. You also indicate in your  
4 Affidavit at paragraphs 23 and 24 that you  
5 still get questions --

6 A. I do.

7 Q. -- and I quote: [AS READ]  
8 " -- whether certain things are  
9 required by the act or the  
10 regulation."

11 So I just want to ask you a little bit more  
12 about that. So are people asking you what does  
13 the act or regulation say, or are they asking  
14 you to help them interpret what the act or  
15 regulation says?

16 A. When I wrote that statement  
17 in the Affidavit, I was thinking very  
18 specifically that it's not at all uncommon for  
19 PSW staff to approach us with, "Do we have to  
20 do this? Is this a Ministry requirement? This  
21 is how it was told to us, that we have to do  
22 this because the Ministry says so."

23 And that's not an uncommon  
24 question that we are asked by staff in the home  
25 by unregulated, frequently PSW staff. And  
26 that's why I'd indicated I will refer them to  
27 the legislation.

28 I'll say, "You know what, I'll  
29 be back up in 20 minutes, and I'll bring the  
30 book, and we'll show you."

31 But I definitely identify as  
32 well that they're required to follow the

12:54:46 1 policies and procedures in the home whether  
12:54:48 2 they exceed our standards or -- or our  
12:54:52 3 regulations or not. See, now standards are in  
12:54:54 4 my head.

12:54:55 5 And they're also required to --  
12:54:57 6 I'm definitely not their supervisor. They're  
12:55:00 7 required to listen to their managers.

12:55:02 8 Q. All right. So I think I  
12:55:02 9 understand that. So when a PSW asks you, "My  
12:55:05 10 director says I have to do this; do I really  
12:55:08 11 have to do this," you don't want to get in  
12:55:11 12 between the PSW and their supervisor?

12:55:12 13 A. Definitely not.

12:55:13 14 Q. So the most you will do is  
12:55:15 15 pull out a copy of the act, show them the  
12:55:17 16 provision in the act, and then direct them back  
12:55:20 17 to their supervisor if they have any questions;  
12:55:20 18 is that fair?

12:55:24 19 A. That is very fair in that  
12:55:26 20 regard.

12:55:26 21 Q. All right. What about  
12:55:28 22 questions, though, from Directors of Care or  
12:55:28 23 Assistant Directors of Care or registered staff  
12:55:30 24 with respect to, "What does the act mean? I  
12:55:34 25 have this particular provision. I'm not sure  
12:55:37 26 what it means." Do you still get those kinds  
12:55:39 27 of questions?

12:55:39 28 A. What does it mean? Can you  
12:55:45 29 give me an example?

12:55:46 30 Q. Well, let's -- we talked a  
12:55:50 31 little bit about the 24/7 requirement and the  
12:55:52 32 fact that that particular section of the act

12:55:54 1 provides that it's only -- but for emergency  
12:55:58 2 situations, that you're supposed to have a  
12:56:01 3 nurse there 24/7 who's a nurse who's on your  
12:56:06 4 permanent staff.

12:56:06 5 Do you recall if anyone ever  
12:56:08 6 asked you, "Well, what constitutes an emergency  
12:56:10 7 situation?" Did you have any discussions with  
12:56:13 8 anyone --

12:56:14 9 A. I believe I had. Yeah, I  
12:56:15 10 don't believe -- I recall I have with staff  
12:56:17 11 from your organization.

12:56:19 12 Q. From Telfer Place?

12:56:20 13 A. Yes.

12:56:24 14 Q. Okay.

12:56:25 15 A. I'm just looking into the act  
12:56:28 16 for Section 45, if that's okay.

12:56:33 17 THE COMMISSIONER: Yes.

12:56:34 18 THE WITNESS: Okay. I'm sorry.

12:56:36 19 I just...

12:56:37 20 Except this one is different  
12:56:47 21 than my book.

12:56:53 22 MR. KLOEZE: Lisa, if you look  
12:56:54 23 at the reg.

12:56:55 24 THE WITNESS: Mine is separate.  
12:56:57 25 I have the reg first, and then  
12:56:58 26 the act, and it is -- yes, this  
12:57:01 27 one is a little bit different.

12:57:02 28 So it goes on -- Section  
12:57:07 29 45(2) identifies in this section  
12:57:10 30 emergency means an unforeseen  
12:57:12 31 situation of a serious nature  
12:57:13 32 that prevents a Registered Nurse

1 from getting to the long-term  
2 care home.

3 So when we have identified  
4 this noncompliance, there was  
5 question about what was an  
6 emergency unforeseen situation  
7 that prevents the Registered  
8 Nurse from getting to the home.

9 And we did identify that  
10 those types of situations would  
11 have to be an unforeseen, an  
12 emergency, and serious.

13 So we said, so if someone  
14 calls in sick with I've just  
15 fallen, and I've broken my leg,  
16 and I have surgery scheduled for  
17 today, I'm supposed to be there  
18 at 3 o'clock and it's 2:30, that  
19 would meet the burden of an  
20 emergency and unforeseen.

21 However, that individual now  
22 can't come to work tomorrow, and  
23 you know that now when she makes  
24 her original phone call, that  
25 would no longer be an unforeseen  
26 situation.

27 So we spoke about should  
28 there be a snowstorm, another  
29 example that Karen Simpson gave,  
30 and the roads were closed. The  
31 ice storm that recently had had.

32 So we talked about that those

12:58:19 1 indeed could be considered an  
12:58:23 2 emergency situation.

12:58:24 3 BY MS. MCALEER:

12:58:24 4 Q. All right. And those were  
12:58:26 5 discussions that you had with individuals at  
12:58:29 6 Telfer Place when you were carrying out the  
12:58:31 7 inspection that was just reviewed with you in  
12:58:33 8 detail?

12:58:33 9 A. That is correct. And when  
12:58:34 10 you say "individuals," I will say it was with  
12:58:37 11 the Executive Director that was there at the  
12:58:40 12 time, Jim Eagleton.

12:58:41 13 Q. So that's the type of  
12:58:43 14 discussion or the type of question to which I  
12:58:45 15 was referring to earlier when I asked you  
12:58:47 16 whether or not nurses or Directors of Care or  
12:58:51 17 Executive Directors, if they ask you for  
12:58:53 18 assistance in interpreting the legislation. Do  
12:58:55 19 you still get those kinds of questions?

12:58:57 20 A. Obviously I did, and I  
12:58:58 21 provided some information about that. And I  
12:59:02 22 needed to provide that information to help him  
12:59:05 23 make decisions about the vacant shifts that  
12:59:11 24 they had and why they needed to fill them.

12:59:14 25 So if he didn't have that  
12:59:17 26 information -- by all means, the exception  
12:59:20 27 would be if there was a two-week period of time  
12:59:24 28 because someone was on vacation, obviously he  
12:59:27 29 can figure out that wasn't an emergency  
12:59:30 30 situation, but if there was sort of one-offs in  
12:59:31 31 there, it would be difficult to tell without  
12:59:33 32 knowing the definition of the emergency.

1 Q. And more generally speaking,  
2 not just with respect to the Telfer inspection  
3 but more generally speaking, are people at any  
4 of the 120 plus homes that you inspect, are the  
5 registered staff or the Directors of Care  
6 asking you for assistance with interpretation  
7 of the legislation? Does that happen  
8 frequently? Infrequently? Not at all?

9 A. I'm going to say with  
10 registered staff, very infrequently. I don't  
11 know -- I don't recall a recent occasion. With  
12 Directors of Nursing, maybe a little more  
13 frequently, but frequently what I would do then  
14 or on those occasions is pull out the  
15 legislation and read it with them, comparing it  
16 to their own policies or protocols or form or  
17 whatever they've got and having them walk  
18 through it as we read together.

19 MS. MCALEER: All right. Those  
20 are all my questions. Thank you  
21 very much.

22 THE WITNESS: Thank you.

23 THE COMMISSIONER: Thank you,  
24 Ms. McAleer.

25 CROSS-EXAMINATION BY MS. FRASER:

26 Q. Ms. Vink, my name is Suzan  
27 Fraser. I'm here on behalf of OARC. I think  
28 you've been following the proceedings in the  
29 room for most of the week; is that fair?

30 A. I've been here for the last  
31 two days, yes.

32 Q. Okay. Thank you. I just

1 want to start with the issue about registration  
2 and find a nurse and the process of checking  
3 that.

4 In the course of any of your  
5 inspections, not just at Telfer Place but in  
6 the course of your duties as an inspector, have  
7 you ever come across situations where somebody  
8 isn't properly registered and is working as a  
9 Registered Nurse or a Registered Practical  
10 Nurse?

11 A. Unfortunately, yes.

12 Q. So there are circumstances  
13 where somebody has been working without proper  
14 qualifications?

15 A. I know of one Registered  
16 Practical Nurse -- I'm sorry. One person who  
17 was working as a Registered Practical Nurse  
18 that was not registered with the College.

19 And I know of one RN who was a  
20 foreign-trained nurse, had submitted paperwork  
21 to the College, but due to some issues, did not  
22 have all of the correct information in place,  
23 and was working without a registration as well.

24 Q. Okay. And were those issues  
25 that were uncovered through the inspection  
26 process?

27 A. No.

28 Q. No.

29 A. One of them was identified  
30 by the media and brought to our attention by  
31 the home post media becoming aware of it. And  
32 the second was identified by the home during a

13:02:46  
13:02:47  
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13:03:38  
13:03:40  
13:03:40  
13:03:43  
13:03:46  
13:03:52  
13:03:57  
13:04:05

1 quality check that they were doing.  
2 Q. Okay. Thank you. I want to  
3 speak a little bit about agency staff. I  
4 understand from reading the act, that Section  
5 74 limits the use of agency staff; is that  
6 right?  
7 A. I'm going to check for you --  
8 Q. Sure.  
9 A. -- if that's all right.  
10 Section 74?  
11 Q. Yes.  
12 A. It does say limited. I've  
13 always looked at this as ensuring consistency  
14 of staff, but it indeed does say: [AS READ]  
15 "Casual and agency staff is  
16 limited in accordance with the  
17 regulations."  
18 Q. Okay. Thank you for that. I  
19 guess I could have read that to you, so thank  
20 you for looking it up for me --  
21 A. No, that's --  
22 Q. -- and doing my work.  
23 But you've understood that as  
24 that's being important. If we limit the use of  
25 agency staff, that has a corollary effect of  
26 ensuring continuity of care for the residents;  
27 is that fair?  
28 A. I feel that staff that know  
29 the residents well not always, but are  
30 frequently -- I feel that there's value in  
31 staff knowing the residents, their care needs,  
32 the residents knowing the staff, that there's a



13:04:07 1 different rapport that's being built.

13:04:10 2 If this is the same person that  
13:04:11 3 you see every morning or five days a week  
13:04:11 4 providing care to you, that there's a different  
13:04:14 5 relationship there than when someone comes in  
13:04:17 6 intermittently, and you don't know their name,  
13:04:19 7 yes.

13:04:19 8 Q. Okay. Thank you. And with  
13:04:21 9 respect to conducting investigations that  
13:04:25 10 relate to agency staff, you could use your  
13:04:30 11 inspection powers, could you not, to compel  
13:04:34 12 documents from agency staff in the course of an  
13:04:38 13 inspection or from the agency itself? We can  
13:04:41 14 turn to Section 147, if you like.

13:04:44 15 A. I will first comment. You  
13:04:46 16 identified when I'm doing investigations, and  
13:04:48 17 I've never done an investigation.

13:04:50 18 Q. I meant to say inspections.

13:04:52 19 A. Okay. There's a  
13:04:54 20 differentiation there, so I just wanted to  
13:04:56 21 clarify that. I'm so sorry. I don't know  
13:05:01 22 remember what leg. ref. you provided me, or  
13:05:01 23 legislative reference.

13:05:02 24 Q. So section 147.

13:05:02 25 A. Thank you.

13:05:03 26 Q. Mr. Golden took us to that.

13:05:05 27 A. Yes.

13:05:05 28 Q. Although it wasn't teed up in  
13:05:11 29 my document list, Laura, it would be at, I  
13:05:11 30 believe, page --

13:05:11 31 MS. STEPHENS: She's already got  
13:05:11 32 it.

13:05:11 1 MS. FRASER: Wow. Can I just  
13:05:12 2 say wow. Thank you very much,  
13:05:17 3 Laura.  
13:05:18 4 THE WITNESS: I am so sorry.  
13:05:21 5 Meagan is already aware I'm not  
13:05:23 6 the best with numbers. Did you  
13:05:24 7 say 147 or 174?  
13:05:27 8 BY MS. FRASER:  
13:05:27 9 Q. 147.  
13:05:28 10 A. Thank you.  
13:05:28 11 Q. I have the exact same problem  
13:05:28 12 in terms of --  
13:05:29 13 A. I'm delighted to hear I'm not  
13:05:31 14 the only one because it's a little bit  
13:05:34 15 embarrassing.  
13:05:34 16 Q. Not everything can play to  
13:05:37 17 our strengths.  
13:05:38 18 Have you got 147?  
13:05:39 19 A. I do. Thank you very much  
13:05:40 20 for your assistance.  
13:05:41 21 Q. So the powers that you have  
13:05:45 22 on an inspection are quite broad, and you  
13:05:54 23 may -- under part D: [AS READ]  
13:05:57 24 "May question a person subject  
13:05:58 25 to the person's right to have  
13:06:00 26 counsel during the questioning."  
13:06:03 27 And my question for you -- [AS READ]:  
13:06:08 28 "You may inspect a copy or a  
13:06:10 29 record under B. You may demand  
13:06:12 30 the production of records or  
13:06:15 31 other things. You may --"  
13:06:19 32 Under part 2, just going down, so subsection 2:

13:06:25 1 [AS READ]  
13:06:25 2 "You may make a written demand."  
13:06:29 3 And I understand under Section 148, which is  
13:06:34 4 the section below, you have -- you may apply  
13:06:40 5 for a warrant.

13:06:40 6 So I guess my question is have you  
13:06:44 7 ever used these powers against an agency?

13:06:48 8 A. Against an employment agency?

13:06:51 9 Q. Yes.

13:06:51 10 A. I have not.

13:06:52 11 Q. Okay. You have not?

13:06:53 12 A. I have definitely sought --  
13:06:57 13 I've used a written demand letter to get  
13:07:00 14 information from a long-term care home. One  
13:07:00 15 had a video of something that they weren't  
13:07:03 16 willing to share, and we were able to get the  
13:07:05 17 video of...

13:07:09 18 I've been aware of situations  
13:07:11 19 where we've received records from the hospital  
13:07:13 20 and from the LHIN as well in a similar sort of  
13:07:16 21 situation. In relation to --

13:07:17 22 Q. I'm going to stop you there.

13:07:17 23 A. Yeah.

13:07:19 24 Q. So you haven't interpreted  
13:07:20 25 these powers as being capable of being used  
13:07:23 26 against agencies other -- sorry, organizations  
13:07:26 27 other than the long-term care home; right?

13:07:32 28 A. I have in that I've gotten  
13:07:35 29 records from the hospital as well as from the  
13:07:38 30 LHIN, so CCAC, initial MDS assessments, and  
13:07:38 31 things like that.

13:07:40 32 Q. Okay. Thank you very much.

1 If I could turn you to page --  
2 or, sorry, paragraph 79 of your Affidavit. I  
3 understand that in the course of your  
4 investigation, that you interviewed -- and this  
5 is spelled out in paragraph 79 of your  
6 Affidavit. You interviewed a Dr. Williams?

7 A. I did.

8 Q. And Dr. Williams told you  
9 that he did not recall Elizabeth Wettlaufer,  
10 but he observed a nurse one night swearing and  
11 being verbally abusive to some residents, but  
12 he did not know the nurse. He did not give you  
13 specific examples about to who or what was  
14 said. He did not witness any physical abuse.

15 And you write in your Affidavit:

16 [AS READ]

17 "I was shocked by this new  
18 allegation which I considered to  
19 be an allegation of abuse."

20 A. That is correct.

21 Q. Okay. And I understand that  
22 you took further steps to explore this with  
23 both Ms. Cornelissen and Mr. Eagleton so that  
24 they could investigate.

25 But you go on at paragraph 80 of  
26 your Affidavit to say that: [AS READ]

27 "In order to make a finding  
28 against the home, the home did  
29 not report Dr. Williams'  
30 allegation of abuse to the  
31 Ministry of Health and long-term  
32 care home, that you would have

13:09:29 1 needed more information such as  
13:09:32 2 what was the alleged abuse, who  
13:09:35 3 the resident was, when it  
13:09:36 4 occurred, and who the nurse  
13:09:40 5 was."  
13:09:41 6 And just going from there, you did not make  
13:09:43 7 such a finding against the home?  
13:09:45 8 A. That's correct.  
13:09:45 9 Q. And so my question for you  
13:09:49 10 really is why? When you have the admission  
13:09:53 11 from the physician who witnesses something that  
13:09:55 12 constitutes abuse and did not report that  
13:09:59 13 abuse, why would you need anything else at that  
13:10:02 14 point in time?  
13:10:02 15 A. This was a very difficult  
13:10:08 16 piece of the inspection. We had started with  
13:10:11 17 an email that Michelle Cornelissen had sent to  
13:10:17 18 Heidi Wilmot-Smith indicating that there  
13:10:30 19 were -- I'm just looking for the verbiage that  
13:10:35 20 was used about EW's -- no, no, I take that  
13:10:39 21 back.  
13:10:40 22 That failure too adequately  
13:10:41 23 assess or check a resident -- oh, no, that's  
13:10:44 24 not it either.  
13:10:45 25 Q. Tab H of your Affidavit.  
13:10:47 26 A. Oh, thank you.  
13:10:48 27 Q. The document number is 41461.  
13:11:02 28 A. Can I start reading or --  
13:11:04 29 Q. Let's just wait until it's up  
13:11:06 30 on the screen so everybody can have it. Okay.  
13:11:11 31 So go ahead.  
13:11:12 32 A. Scroll down. The very

1 last -- yeah, the bullet point number 2 there.

2 So this an email from Michelle Cornelissen

3 April the 20th of 2016, addressed to Heidi.

4 [AS READ]:

5 "Further, the physician was in  
6 today and brought up concerns  
7 related to Bethe as well and did  
8 not feel confident in her  
9 abilities to assess our  
10 residents and carrying out basic  
11 nursing duties.

12 The physician also mentioned  
13 that he felt she lacked  
14 accountability as a nurse to the  
15 residents of the home."

16 So Michelle Cornelissen was in the home for  
17 approximately two weeks when she received this  
18 information. I had spoke with --

19 Q. Her job for two weeks?

20 A. So in the home. She was a  
21 new employee to the home, so wasn't familiar  
22 with the residents, even the building, things  
23 like that.

24 So when we interviewed her in --  
25 I believe it was November, we asked her, "Who  
26 was the physician? What exactly did he say?  
27 What made you say that he did not feel  
28 comfortable in her abilities to assess the  
29 residents, carry out basic nursing?"

30 Basically what was said was the  
31 gist of our question and who said it. She  
32 said, "Honestly, I don't remember."

1 And in all fairness, being in a  
2 brand new home at that time, I understood that.  
3 But she said, "It's definitely one of two  
4 physicians." And she identified Dr. Williams  
5 as being one of the two.

6 So we went to the physicians to  
7 speak with them about what they had potentially  
8 reported.

9 Q. Yes.

10 A. We spoke with the first  
11 physician, Dr. McDonald, and he had indicated  
12 that although he had voiced some concerns about  
13 something, it was not at all about one person  
14 in particular, hence we thought that it was not  
15 him that had made this concern.

16 I spoke with the second  
17 physician, Dr. Williams, who had indicated what  
18 I have here. Basically, no, they weren't  
19 concerns about her assessment or carrying out  
20 basic nursing duties or her -- that there was  
21 an allegation -- that I had witnessed her  
22 talking roughly to a resident or -- and I'm so  
23 sorry. I don't have the exact words in front  
24 of me now, but something that made me think it  
25 was abuse.

26 So that was not what I was  
27 expecting to hear at all. I was expecting to  
28 hear that maybe she wasn't good at assessing  
29 when a resident had congestive heart failure or  
30 something to that degree. I was not  
31 anticipating this information at all.

32 He couldn't give me any

13:14:10 1 specifics as to who the resident was, what was  
13:14:13 2 said. He knew he had come in later in an  
13:14:16 3 evening, and that's when it had happened. He  
13:14:19 4 couldn't -- he couldn't recall that  
13:14:22 5 information.

13:14:23 6 But he went on to say that he  
13:14:28 7 was aware that the police had had an email  
13:14:31 8 where there was another concern about her,  
13:14:34 9 about her, the nurse, as well, that he didn't  
13:14:39 10 know it was that nurse until sort of he put two  
13:14:41 11 and two together after sort of everything had  
13:14:44 12 come to light. And I'm paraphrasing here, and  
13:14:47 13 I apologize for that.

13:14:51 14 Q. Right, but he was -- he did  
13:14:52 15 not -- even though he didn't know the identity,  
13:14:55 16 and he was sort of speculating by putting the  
13:14:58 17 two and two together, he was certain of what he  
13:15:01 18 witnessed in terms of witnessing this verbal  
13:15:04 19 abuse towards a resident?

13:15:07 20 A. I don't know who the resident  
13:15:08 21 was. I don't know the date. I don't know what  
13:15:10 22 was said. I don't know if it's then verbal  
13:15:12 23 abuse or emotional abuse. I -- there were so  
13:15:17 24 many things I didn't know.

13:15:19 25 So at that time, I called  
13:15:21 26 Michelle Cornelissen back, as you mentioned,  
13:15:22 27 and I said, "Michelle, this is what I've now  
13:15:24 28 heard."

13:15:25 29 And she said, "No, no, no, no,  
13:15:26 30 no, no, no, that's not what was told to me at  
13:15:29 31 all. Although I don't remember exactly what  
13:15:30 32 was shared with me, it wasn't that."



13:15:34 1 Q. But she could have been  
13:15:36 2 speaking about Dr. McDonald because we've heard  
13:15:36 3 from Dr. McDonald here that he had concerns  
13:15:36 4 about her when he was talking to Elizabeth  
13:15:36 5 Wettlaufer, and she had sort of I think -- I'm  
13:15:46 6 paraphrasing, but a blank look on her face like  
13:15:47 7 as if she didn't know what she was doing.

13:15:51 8 But what concerns me is that  
13:15:54 9 your statement essentially is that you have to  
13:15:57 10 look for other evidence to support this when on  
13:16:00 11 the face of it, there's abuse, and that's  
13:16:03 12 the -- let me just finish. And that's the  
13:16:09 13 uncontroverted part.

13:16:10 14 A. I apologize for jumping in.

13:16:13 15 Q. No trouble.

13:16:14 16 A. I think that in order for me  
13:16:14 17 to leave a finding of noncompliance, I need to  
13:16:15 18 inspect it. I need to be able to inspect the  
13:16:28 19 issue that is given to me to be able to  
13:16:28 20 identify it as noncompliant.

13:16:28 21 And for me to have one person at  
13:16:29 22 some time did something -- in order for me to  
13:16:37 23 potentially inspect this, I spoke with the  
13:16:38 24 current Executive Director in the home at the  
13:16:40 25 time, and he was aware of the email, although  
13:16:42 26 was not the recipient of it, the Michelle  
13:16:48 27 Cornelissen email. And I shared with him what  
13:16:50 28 was shared with me by Dr. Williams.

13:16:51 29 And I asked him to please follow  
13:16:52 30 up with the physician. He made efforts to do  
13:16:57 31 that, and unfortunately, the physician at this  
13:17:00 32 time, which was, of course, after my discussion

13:17:03 1 with him -- so even a little bit later after  
13:17:05 2 the fact -- could not provide any specifics as  
13:17:08 3 well. So I had nothing to inspect, no specific  
13:17:14 4 information to inspect upon.

13:17:17 5 If I could also add -- and I've  
13:17:19 6 acknowledged here that I do have a couple of  
13:17:21 7 issues with numbers in my life. There was a  
13:17:23 8 typo in my error of my note with Dr. Williams.

13:17:28 9 I had identified it was a  
13:17:29 10 discussion in relation to an incident in 2015.  
13:17:33 11 That should have said 2016.

13:17:36 12 Q. Okay. All right. I don't  
13:17:43 13 know if we're going to get any further ahead on  
13:17:45 14 my question because I would think that the  
13:17:48 15 issue is really about the reporting, where  
13:17:54 16 somebody feels that the -- sorry, I'll word it  
13:18:00 17 again.

13:18:00 18 Is that in terms of time or  
13:18:02 19 place, that may not matter. The issue here was  
13:18:04 20 you have a member of the professional staff who  
13:18:08 21 witnesses what you consider to be abuse, which  
13:18:12 22 he calls verbally abusive, and they don't  
13:18:14 23 report, and all of that seems uncontroverted,  
13:18:19 24 and you can't make a finding about it.

13:18:22 25 You'd agree that that's sort of  
13:18:23 26 where we're at with what you've told us?

13:18:26 27 A. I will say the decision I  
13:18:28 28 made at that time was that I could not inspect  
13:18:30 29 it further or I could not inspect it. And you  
13:18:33 30 are correct. I did not make a finding of  
13:18:36 31 noncompliance in that regard.

13:18:37 32 Q. Okay. So if we could --

13:18:44 1 A. And I apologize that I  
13:18:45 2 paraphrased what was said to me, but that's to  
13:18:48 3 the best of my recall.

13:18:48 4 Q. That's okay. I'd like to  
13:18:50 5 take you to Exhibit I of your Affidavit,  
13:18:52 6 Document 41407, please.

13:19:00 7 A. Yes.

13:19:01 8 Q. We're going to go to page 30  
13:19:02 9 of that document which I understand detail your  
13:19:07 10 notes of your conversation with the family?

13:19:15 11 A. Yes. I'm there.

13:19:17 12 Q. And does this -- the notes  
13:19:23 13 that are found here in your Ad Hoc Notes, do  
13:19:27 14 they represent a summary of the trans -- your  
13:19:29 15 notes of the call that you had with the family?

13:19:31 16 A. So we, myself as the speaker  
13:19:37 17 and Lesley Edwards as the scribe, made this  
13:19:41 18 phone call in a secured area in the Hamilton  
13:19:44 19 Service Area Office where we have privacy.

13:19:46 20 The phone call was made on the  
13:19:47 21 phone. The family were aware that there was  
13:19:50 22 two of us on the call. Lesley took notes as I  
13:19:54 23 spoke with the family. And this is a type of  
13:19:56 24 our written notes.

13:19:58 25 Q. Okay. And you made them at  
13:19:59 26 the time?

13:19:59 27 A. Lesley recorded them as I  
13:20:01 28 spoke.

13:20:02 29 Q. Okay. And did you get a  
13:20:04 30 chance to look at them afterwards to see if  
13:20:06 31 they reflected what happened in the call?

13:20:08 32 A. I have no reason to believe

13:20:10 1 they did not reflect what happened in the call.

13:20:13 2 Q. Okay. And there --

13:20:16 3 A. They're my -- they're my  
13:20:19 4 Ad Hoc Notes, so I indeed wrote them. If I  
13:20:22 5 would have had -- although Lesley handwrote  
13:20:25 6 them, I typed them. If I would have had  
13:20:27 7 concerns, I would have brought them to her  
13:20:27 8 attention.

13:20:30 9 So, yes, it would have been  
13:20:32 10 accurate and true to my recall at the time that  
13:20:33 11 I typed them out, which would have been quite  
13:20:35 12 shortly after our call.

13:20:36 13 Q. Okay. So I'm wondering if  
13:20:37 14 you can just tell us -- I'm interested in terms  
13:20:43 15 of the part starting with -- so the family  
13:20:52 16 talks about the hospital transfer that I'm not  
13:20:55 17 going to take you to.

13:20:56 18 They talk about how they  
13:20:59 19 historically had no care concerns, and they're  
13:21:01 20 realistic, and they make some comments about  
13:21:04 21 the home, that the home was never dirty. Her  
13:21:08 22 briefs are changed. Her room is clean. No  
13:21:11 23 orders in the home. The care and the empathy  
13:21:14 24 of the staff is excellent. So they were  
13:21:17 25 content with the care?

13:21:18 26 A. They were.

13:21:19 27 Q. But they did identify that he  
13:21:23 28 knows now that the nurse still worked at the  
13:21:25 29 home after this. And he did note that at  
13:21:27 30 times -- what he meant by "after this," you  
13:21:32 31 understood that to be after the incident?

13:21:34 32 A. Correct, so after the

13:21:35 1 incident of low blood sugars.

13:21:37 2 Q. Yes.

13:21:38 3 A. Yes.

13:21:38 4 Q. As a consequence of

13:21:41 5 Ms. Wettlaufer's --

13:21:41 6 A. Yes.

13:21:41 7 Q. -- injection of medication.

13:21:46 8 So after -- I'm just trying to

13:21:51 9 find my place. After this -- and he did note

13:21:51 10 that: [AS READ]

13:21:55 11 "At times, his mom, Sandy, was

13:21:58 12 agitated when he would come to

13:22:00 13 visit and wonders. He did

13:22:03 14 identify that his mom's

13:22:04 15 condition had changed

13:22:05 16 drastically over the years and

13:22:07 17 that she no longer demonstrated

13:22:10 18 agitation."

13:22:13 19 And I just wanted to confirm with you that what

13:22:13 20 I understood is that following this incident,

13:22:14 21 when Ms. Wettlaufer was still working in the

13:22:16 22 home, he was looking back, thought the times

13:22:20 23 when his mother was agitated related to her

13:22:23 24 being in the home.

13:22:23 25 A. My recall of the conversation

13:22:27 26 is that he was aware -- this was a difficult

13:22:38 27 phone call in that the home -- I'm so sorry.

13:22:42 28 The family were not aware exactly what had

13:22:44 29 happened to mom, and we reached out to them to

13:22:46 30 talk to them. And they wanted answers for us,

13:22:49 31 and I, of course, couldn't give them.

13:22:51 32 Q. Right.

13:22:52 1 A. So there was a little bit of  
13:22:57 2 circling because I couldn't -- and they were  
13:23:02 3 lovely, gracious people who only want what's  
13:23:07 4 best for mom, of course.

13:23:09 5 So he -- they had reflected.  
13:23:12 6 They now knew that something untoward had  
13:23:15 7 happened to mom. And then they said, "Oh, but  
13:23:17 8 we also know that this individual continued to  
13:23:19 9 work with mom. And sometimes when we would  
13:23:25 10 visit mom, she was agitated, but we didn't know  
13:23:29 11 why. And maybe, maybe did something else  
13:23:31 12 happen to her? We don't know now. We're, of  
13:23:34 13 course, speculating, but, again, she's our mom,  
13:23:36 14 and we only want what's best for her." At  
13:23:41 15 least that's how I understood the conversation.

13:23:42 16 Q. Thank you. I also understand  
13:23:43 17 in the course of your interviews with  
13:23:46 18 Ms. Cornelissen, that you had an opportunity to  
13:23:48 19 address inappropriate comments that were made  
13:23:51 20 by Ms. Wettlaufer?

13:23:53 21 A. Inappropriate comments to  
13:23:56 22 whom?

13:23:56 23 Q. Towards staff.

13:23:59 24 MS. FRASER: And, Madam

13:24:00 25 Commissioner, they're not nice,  
13:24:01 26 and they're rude, but I think  
13:24:03 27 it's important for you to know  
13:24:05 28 them, and I think it's important  
13:24:06 29 to know because they're going to  
13:24:08 30 relate to what the obligations  
13:24:09 31 are when somebody is making  
13:24:11 32 inappropriate remarks to staff.

13:24:13 1 Okay?

13:24:13 2 THE COMMISSIONER: I'm

13:24:17 3 listening.

13:24:17 4 BY MS. FRASER:

13:24:17 5 Q. So if you could go to Tab J,

13:24:19 6 which is Document 41409. And I am going to

13:24:31 7 take you to -- so it's page 35. Actually, if

13:24:38 8 we could start at the bottom of page 34,

13:24:42 9 please, Laura.

13:24:49 10 A. I'm so sorry. You said

13:24:52 11 Tab J? There's no -- it stops at 27.

13:24:56 12 I believe you probably mean my Ad Hoc Notes.

13:24:58 13 Q. Yes.

13:24:59 14 A. Which would then be Tab I.

13:25:02 15 Q. Yes. Thank you.

13:25:14 16 MS. STEPHENS: Laura, that's

13:25:15 17 41407.

13:25:16 18 MS. FRASER: Thank you. See, I

13:25:19 19 told you, I also have trouble

13:25:23 20 with numbers.

13:25:26 21 BY MS. FRASER:

13:25:28 22 Q. Okay. So we're going to go

13:25:29 23 to the bottom of page 34. So you're talking to

13:25:32 24 the Director of Care. And you're -- at

13:25:38 25 question 10, you ask her: [AS READ]

13:25:40 26 "Do you recall if the agency

13:25:41 27 staff nurse EW ever worked at

13:25:45 28 the long-term care home, LTCH,

13:25:46 29 and did you have any concerns

13:25:48 30 related to her practice?"

13:25:50 31 And then she starts off with some concerns --

13:25:52 32 or some introductory comments. And then you

13:25:55 1 put in capital letters: [AS READ]  
13:25:57 2 "She was then given her email to  
13:25:59 3 review."  
13:25:59 4 You're nodding your head yes?  
13:26:03 5 A. Yes.  
13:26:03 6 Q. Okay. And that's the email  
13:26:03 7 we just looked at?  
13:26:04 8 A. Yes. Can I just add one  
13:26:06 9 comment, though? So Michelle Cornelissen  
13:26:08 10 was -- you'd indicated she was the DOC. She  
13:26:08 11 was no longer the DOC at the home at this time.  
13:26:11 12 She had now moved to another home and was DOC  
13:26:15 13 there, and we went to her other home to  
13:26:17 14 interview her. So she was the former DOC at  
13:26:21 15 the home at the time.  
13:26:22 16 Q. But you're talking to  
13:26:23 17 Michelle in this interview?  
13:26:25 18 A. Correct.  
13:26:25 19 Q. Okay. So then she heard from  
13:26:28 20 staff rumours, and I just want to identify what  
13:26:31 21 the rumours were. Lynn Jackson, PSW, she  
13:26:38 22 thinks there may have been otherwise in the  
13:26:39 23 union rep regarding on nights. And then it  
13:26:41 24 says in brackets: [AS READ]  
13:26:42 25 "EW worked mostly nights at the  
13:26:45 26 home, and the union rep worked  
13:26:47 27 evenings. Most off-the-cuff  
13:26:48 28 statements and comments. She,  
13:26:51 29 the RN" --  
13:26:52 30 And that means Ms. Wettlaufer?  
13:26:53 31 A. Yes.  
13:26:53 32 Q. [AS READ]:



13:26:54 1 "-- made statements about  
13:26:55 2 requesting sperm from male staff  
13:26:58 3 and from Lynn putting Tic Tacs  
13:27:00 4 in her vagina when med went down  
13:27:03 5 on her so that she was fresh  
13:27:05 6 when they went down on her."

13:27:07 7 A. I have to apologize. There's  
13:27:08 8 another typo error. That should say "men went  
13:27:12 9 down on her" and not "med."

13:27:14 10 Q. I see. [AS READ]:

13:27:15 11 "There were signs posted in the  
13:27:16 12 staff bathroom."

13:27:17 13 And then it goes on to describe concerns that  
13:27:20 14 they had finding feces all over and on the  
13:27:24 15 stall walls, and staff were thinking that it  
13:27:28 16 was from RN EW, although the ADOC identified  
13:27:32 17 there was no proof. Just staff saying that.

13:27:37 18 So whether or not that's true or  
13:27:38 19 not, my concern is is that -- my question for  
13:27:42 20 you is is there something in your inspection  
13:27:48 21 protocol where there's what I would call  
13:27:49 22 inappropriate behaviour identified with a  
13:27:53 23 professional staff towards another staff, does  
13:27:58 24 that get triggered anywhere in your inspection  
13:28:00 25 protocols?

13:28:01 26 A. It does not. Our regulations  
13:28:04 27 are related to the safeguards of residents in  
13:28:09 28 long-term care homes and not in relation to  
13:28:13 29 staff-to-staff interactions that are outside of  
13:28:18 30 a resident.

13:28:19 31 Q. Right. Just so you know --  
13:28:19 32 this isn't the -- and I'm going to set up the

13:28:24 1 question. Isn't the first time we've heard of  
13:28:26 2 her -- at Caressant Care, there was an  
13:28:28 3 allegation that she was hitting on the students  
13:28:31 4 who worked in the home.

13:28:32 5 And so I'm just wondering  
13:28:34 6 whether you think it would be a good idea for  
13:28:38 7 an inspection to draw out issues relating to a  
13:28:44 8 professional staff of harassing behaviour  
13:28:47 9 towards another as part of your evaluation of  
13:28:50 10 the care that's being provided.

13:28:53 11 I guess my thinking is is that  
13:28:54 12 if somebody is making these comments towards a  
13:28:58 13 professional staff, what might they be doing  
13:29:03 14 towards a resident who might not be able to  
13:29:06 15 speak up.

13:29:06 16 So just with that sort of  
13:29:07 17 backdrop, do you think it's a good idea for the  
13:29:10 18 inspection protocol to kind of draw out this  
13:29:11 19 kind of conduct?

13:29:14 20 A. In my opinion, most long-term  
13:29:19 21 care homes have other avenues to deal with  
13:29:22 22 staff issues, whether it be a unionized  
13:29:31 23 environment or even non-unionized environment  
13:29:35 24 have other mechanisms of dealing with employee  
13:29:40 25 issues.

13:29:46 26 I've always looked at my role as  
13:29:48 27 one of advocating for the resident. I'm not  
13:29:52 28 saying that indeed if you would conduct  
13:29:57 29 yourself this way with a staff member that you  
13:30:00 30 would be totally different with a resident.  
13:30:03 31 I'm not saying that at all, but I don't know  
13:30:05 32 that necessarily one means the other, in my

13:30:14 1 opinion.

13:30:14 2 Q. All right.

13:30:15 3 MS. FRASER: Just -- I'm looking  
13:30:26 4 at Ms. Meadus because we're  
13:30:27 5 always thinking about our time,  
13:30:30 6 Commissioner.

13:30:30 7 BY MS. FRASER:

13:30:31 8 Q. We have heard testimony --  
13:30:37 9 I'm leaving this topic that we were on -- from  
13:30:41 10 the Executive Director, who is not a nurse,  
13:30:44 11 including insulin under the supervision of an  
13:30:48 12 RPN. You're aware of that testimony?

13:30:51 13 A. I was here when Dian Shannon  
13:30:53 14 testified, as well as I was previously aware of  
13:30:56 15 the finding of noncompliance.

13:30:57 16 Q. Right. And I think you deal  
13:30:59 17 with that in your Affidavit. I -- just for the  
13:31:05 18 record --

13:31:05 19 A. I don't believe I deal with  
13:31:07 20 it in my Affidavit.

13:31:09 21 Q. Okay. I'm mistaken then.  
13:31:14 22 My question for you is it's  
13:31:17 23 clear that the regulations to the Long-Term  
13:31:21 24 Care Homes Act prohibit a nurse from delegating  
13:31:23 25 anything but a topical; am I right about that?

13:31:28 26 A. The medication should not --  
13:31:30 27 the insulin should not have been administered  
13:31:33 28 by the Director of -- or by the Executive  
13:31:35 29 Director who was not a registrant of the  
13:31:37 30 College. You are correct.

13:31:39 31 Q. Okay.

13:31:39 32 A. There are certain people in

13:31:41 1 the legislation who are allowed to administer  
13:31:43 2 medications: Registered staff with the  
13:31:46 3 College, dentist, and a physician I believe is  
13:31:49 4 the entire group of individuals who are able to  
13:31:54 5 do that.

13:31:55 6 Q. Okay. And I understand --  
13:32:02 7 and just looking at Exhibit F to your  
13:32:05 8 Affidavit, which is Document 41487.

13:32:16 9 A. Yes.

13:32:16 10 Q. And this is just leaving the  
13:32:21 11 topic of that. Is that over the identified --  
13:32:28 12 sorry, a review of the schedules is where I'm  
13:32:30 13 interested in. So this is page 4 of this  
13:32:33 14 document. [AS READ]

13:32:43 15 "A review of the schedules by  
13:32:45 16 Scheduler 616" --  
13:32:48 17 So that's a little bit further down the page.  
13:32:50 18 Yeah. [AS READ]:

13:32:52 19 " -- confirmed that over the  
13:32:53 20 identified period of time, there  
13:32:55 21 were over 25 occasions where the  
13:32:59 22 only RN in the home was an  
13:33:01 23 agency RN and 7 occasions where  
13:33:03 24 there was only an RPN employed  
13:33:05 25 in the home."

13:33:05 26 Right?

13:33:07 27 A. Maybe it shouldn't say  
13:33:09 28 employed, but working.

13:33:10 29 Q. Working?

13:33:11 30 A. Yeah.

13:33:11 31 Q. Okay.

13:33:12 32 A. Sorry, that maybe wasn't the

1 best word choice there.

2 Q. All right. [AS READ]:

3 "And it was verified by the ED  
4 that agency RNs were not members  
5 of the regular nursing staff and  
6 that no circumstances were  
7 present to their knowledge which  
8 permitted an exception to the  
9 requirements of Section 8(3)."

10 And can you just remind me what 8(3) is again?

11 A. That's this legislative  
12 reference, 24/7 RN, an RN in the building at  
13 all times who's a member of the regular  
14 registered nursing staff.

15 Q. And are you aware of  
16 inspections that have been conducted subsequent  
17 to yours that Telfer Place is still having  
18 trouble meeting that RN --

19 A. I'm actually aware there was  
20 a follow-up inspection to this one. It was --  
21 I'm so sorry. That's a poor choice of words.

22 There was a subsequent  
23 inspection to this one where the issue was  
24 still identified. A compliance order was  
25 identified at that time. Just prior to  
26 Christmas at this year, that order was  
27 complied. And more recently, they --

28 Q. Go ahead.

29 A. I probably shouldn't -- I  
30 don't know if the report has been released yet  
31 or not.

32 Q. Okay. Well, we have -- I

13:34:18 1 think I have the order that you're referring to  
13:34:20 2 in my document notice, which is Document 42348.  
13:34:30 3 And I'm going to show it to you.

13:34:38 4 A. Thank you.

13:34:39 5 Q. Is this the compliance order  
13:34:56 6 to which you're referring?

13:34:58 7 A. Yes, it is.

13:34:59 8 MS. FRASER: Commissioner, may  
13:35:00 9 that be the next exhibit?

13:35:01 10 THE COMMISSIONER: Yes.

13:35:02 11 Madam Clerk, I think that's  
13:35:04 12 Exhibit 146; is that correct?

13:35:06 13 THE REGISTRAR: That's right.

13:35:07 14 THE COMMISSIONER: Thank you.  
13:35:08 15 Exhibit 146, then, is

13:35:12 16 Document 42348, an inspector's  
13:35:16 17 order dated -- what's the date  
13:35:16 18 of it? Not the inspection date.

13:35:16 19 MS. FRASER: I've given all my  
13:35:27 20 copies away, Commissioner.

13:35:27 21 MS. MEADUS: August 3rd.

13:35:28 22 THE COMMISSIONER: Thank you.  
13:35:29 23 Dated August 3, 2017.

13:35:31 24 Thank you.

13:35:15 25 EXHIBIT NO. 146: Inspector's  
13:35:16 26 Order dated August 3, 2017,  
13:35:11 27 Document 42348.

13:35:33 28 MS. FRASER: Commissioner, those  
13:35:35 29 are my questions, and I'm  
13:35:36 30 grateful to one of the other  
13:35:38 31 participants who's given us some  
13:35:40 32 of their time.

13:35:42 1 THE COMMISSIONER: Thank you.

13:35:47 2 MS. STEPHENS: I think we

13:35:49 3 should, just for record keeping

13:35:51 4 purposes because we are

13:35:52 5 circulating time at the end of

13:35:54 6 each day, that was CNO who had

13:35:57 7 agreed to give some of their

13:35:58 8 extra time. Okay. Thank you.

13:36:01 9 And I'm not sure. Is anyone

13:36:03 10 else --

13:36:08 11 MS. COONEY: Good afternoon,

13:36:14 12 Commissioner.

13:36:10 13 CROSS-EXAMINATION BY MS. COONEY:

13:36:10 14 Q. Good afternoon, Lisa. I just

13:36:17 15 have one very brief question for you.

13:36:19 16 Ms. Fraser asked you about circumstances in

13:36:21 17 which you had found individuals who were

13:36:24 18 practicing nursing but who were not registered

13:36:27 19 with the College?

13:36:29 20 A. Yes.

13:36:29 21 Q. To your knowledge, were those

13:36:31 22 matters ever reported to the College?

13:36:32 23 A. So I'll -- I'll change your

13:36:35 24 statement slightly in you said circumstance

13:36:38 25 which I had found, but I had become aware of.

13:36:40 26 I didn't find them. Where they reported to the

13:36:44 27 College? Yes, the College was aware in both

13:36:47 28 situations. The College was involved in that,

13:36:50 29 yes. And although I did not have direct

13:36:52 30 conversation with the College, I had written

13:36:55 31 communication from the College.

13:36:59 32 MS. COONEY: Thank you.

13:36:59 1 THE COMMISSIONER: Thank you  
13:37:00 2 very much.  
13:37:04 3 MR. KLOEZE: Good afternoon,  
13:37:07 4 Commissioner.  
13:37:09 5 THE COMMISSIONER: Good  
13:37:09 6 afternoon.  
13:37:10 7 RE-EXAMINATION BY MR. KLOEZE:  
13:37:10 8 Q. Good afternoon, Lisa. I just  
13:37:11 9 have one area of questions. If you can turn to  
13:37:14 10 Tab I of the document in front of you of your  
13:37:18 11 brief, and that -- these are your Ad Hoc Notes.  
13:37:23 12 And I'm going to -- it's Document 41407, Laura.  
13:37:28 13 And I'm going to ask you to turn up page 18 of  
13:37:30 14 that in the middle of the page.  
13:37:37 15 And, Lisa, Ms. Fraser was asking  
13:37:40 16 you questions about a conversation you had with  
13:37:43 17 Dr. Williams?  
13:37:44 18 A. Yes.  
13:37:44 19 Q. And I just wanted to put your  
13:37:47 20 notes on the screen so that you could look at  
13:37:50 21 them and let us know what information  
13:37:55 22 Dr. Williams gave you. And that's starting the  
13:37:59 23 paragraph "he confirmed." These are your notes  
13:38:03 24 of your conversation with Dr. Williams?  
13:38:07 25 A. They are my notes of my  
13:38:09 26 conversation with Dr. Williams. It is  
13:38:11 27 acknowledged that they are not verbatim. And  
13:38:17 28 that is the sentence as well that -- it should  
13:38:20 29 read back in 2016, not back in 2015. But you  
13:38:23 30 would like me to read the statement?  
13:38:25 31 Q. So the information -- we  
13:38:26 32 don't have to read it, but the information he



1 gave you, from what I can see here, is that he  
2 noted a nurse to be swearing and verbally  
3 abusive to some residents.

4 A. [AS READ]:

5 "He came in to do evening rounds  
6 one night and noted a nurse was  
7 swearing and verbally abusive to  
8 some residents. He did not know  
9 who she was. Her behaviour was  
10 not acceptable. There was  
11 no" --

12 So I then attempted to probe for additional  
13 information. [AS READ]:

14 "There was no physical abuse,  
15 swearing, and threatening. He  
16 could" --

17 It said he did not, but he could not give me  
18 any specific examples regarding who or what was  
19 said.

20 Q. Okay. That was sort of the  
21 whole information -- go ahead.

22 A. That was the gist -- I'm  
23 sorry. I shouldn't have spoke over you. That  
24 was the gist of the conversation, yes.

25 Q. You reported that, as I  
26 understand, to the administrator?

27 A. Initially, I spoke with  
28 Michelle Cornelissen, the former Director of  
29 Nursing, and the reason I did that is because  
30 she was the one who was in receipt of this  
31 information, and I thought it might help jog  
32 her memory a little bit.

1                   Because my original conversation  
2 was she couldn't really remember, so I thought,  
3 oh, now I have a little bit more information.  
4 It's definitely different information, but it's  
5 different, and this might help her.

6                   And she said, "No, no, not at  
7 all." She knew right away that was something  
8 that was reportable and that that -- she would  
9 have dealt with much differently.

10                  Q. And so as I understand it,  
11 she told you that she did not recall getting  
12 this information from the doctor?

13                  A. She did not receive this  
14 information to the doctor -- from the  
15 physician. She was quite firm on that. In  
16 fact, at the end of that second conversation  
17 with Michelle, she had said, "In fact, now  
18 I think it was probably Dr. McDonald that  
19 shared the concern with me, not Dr. Williams."

20                  Q. And you also advised the  
21 administrator that you had received this  
22 information from Dr. Williams?

23                  A. I did. So the day that we  
24 had spoke with -- or the day that I had spoke  
25 with Dr. Williams, I had received this  
26 information. I then called Michelle  
27 Cornelissen. Fortunately, I was able to speak  
28 with her. She shared me with (sic) what she  
29 knew, which was that was not to her recall at  
30 all.

31                  So I then that very same day  
32 that I received the information took it to the

13:40:32 1 current Executive Director at the home, shared  
13:40:35 2 with him what was shared with me in an effort  
13:40:38 3 to him -- for him to be able to get some --  
13:40:41 4 hopefully get some more specific information  
13:40:43 5 about the who, what, where, when, and why as  
13:40:48 6 Rhonda has shared.

13:40:49 7 Q. And did you get any more  
13:40:50 8 specific information from Mr. Eagleton?

13:40:50 9 A. We -- unfortunately --  
13:40:51 10 unfortunately, Jim was not able to -- I'm  
13:40:55 11 sorry. Mr. Eagleton was not able to talk to  
13:40:55 12 the physician that day.

13:40:56 13 He did follow -- this was near  
13:40:59 14 the holiday season, Christmas, and I believe  
13:41:02 15 approximately a week later, he followed up with  
13:41:05 16 my colleague, Lesley Edwards, and told her that  
13:41:09 17 he could not get any additional information,  
13:41:13 18 that -- that although he was able to speak with  
13:41:16 19 the physician, the physician did not have any  
13:41:19 20 specific information to share at that time.

13:41:20 21 Q. Now, you told Ms. Fraser that  
13:41:23 22 normally, if you get an allegation of abuse,  
13:41:26 23 you would need to inspect it -- or you would  
13:41:28 24 inspect it, but you would need more  
13:41:30 25 information?

13:41:30 26 A. If I get an allegation of  
13:41:32 27 abuse, it would be inspected upon. In order  
13:41:39 28 for me to make a finding of noncompliance, I  
13:41:42 29 would need to be able to inspect it, so I would  
13:41:45 30 need sufficient information to conduct an  
13:41:47 31 inspection.

13:41:48 32 Q. And can you describe that a

1 bit? What kinds of -- what kinds of  
2 information would you need and what kinds of  
3 questions would you be asking or information  
4 you'd be looking for?

5 A. So even if he didn't know who  
6 was the nurse, who was the resident? Who was  
7 around? Who was maybe a witness? Who else  
8 would be able to tell me when this happened,  
9 what was said, who it was said to?

10 We have, as Karen Simpson  
11 pointed out, some definitions of abuse under  
12 the act, and there's a difference between  
13 verbal abuse and emotional abuse. And  
14 sometimes that differentiation comes down to  
15 does the resident understand what's going on.

16 If it's -- it's hard to consider  
17 it to be verbal abuse if the resident maybe  
18 hasn't heard what you said or can't understand  
19 what you said. So for that reason, it might be  
20 a more appropriate fit as emotional abuse.

21 So I would need some basic  
22 tombstone information to be able to inspect  
23 upon that. I needed to know more than some  
24 evening, something was said to somebody, and I  
25 don't really have any specifics.

26 Q. Okay. Thank you for that  
27 clarification. That's the only question I had.

28 MR. KLOEZE: Thank you,  
29 Commissioner.

30 THE COMMISSIONER: Thank you so  
31 much.

32 MS. STEPHENS: I believe that's

13:43:04 1 it, Commissioner. And we have  
13:43:05 2 no further questions for Lisa.  
13:43:08 3 THE COMMISSIONER: All right.  
13:43:09 4 Thank you so much, Ms. Vink.  
13:43:11 5 That means you're free to go.  
13:43:13 6 We appreciate your help very  
13:43:15 7 much.  
13:43:15 8 THE WITNESS: Thank you very  
13:43:19 9 much.  
13:43:19 10 MS. STEPHENS: Commissioner,  
13:43:25 11 I think Mr. Scott maybe has one  
13:43:27 12 brief request.  
13:43:28 13 THE COMMISSIONER: All right.  
13:43:30 14 MR. SCOTT: Good afternoon,  
13:43:36 15 Commissioner.  
13:43:36 16 THE COMMISSIONER: Good  
13:43:38 17 afternoon.  
13:43:38 18 MR. SCOTT: In the words of  
13:43:39 19 Justice Laskin, I'm going to  
13:43:41 20 disbench with the wind-up and  
13:43:43 21 just make my pitch.  
13:43:43 22 THE COMMISSIONER: All right.  
13:43:45 23 MR. SCOTT: We are out of time.  
13:43:46 24 The families have used up the  
13:43:48 25 two hours that was allotted to  
13:43:50 26 us for this block.  
13:43:51 27 Now, I haven't had an  
13:43:53 28 opportunity to go to my  
13:43:54 29 colleagues and see if they've  
13:43:56 30 got some access.  
13:43:57 31 And part of that is a number  
13:43:58 32 of them are not here at this

13:44:01 1 stage, so I thought perhaps I  
13:44:03 2 would come directly to you and  
13:44:06 3 request an additional hour.  
13:44:09 4 One of the things next  
13:44:10 5 week -- I believe we have four  
13:44:11 6 witnesses to hear from, and two  
13:44:15 7 of them will be directly related  
13:44:16 8 to the home care and community  
13:44:20 9 provision of nursing services.  
13:44:23 10 And so I have a bit of a  
13:44:25 11 specific interest in being able  
13:44:26 12 to cross-examine those  
13:44:28 13 witnesses.  
13:44:29 14 I may not need a full hour.  
13:44:31 15 I think, as we saw earlier this  
13:44:33 16 week, the general perception is  
13:44:35 17 that I tend to be brief in my  
13:44:37 18 cross-examination.  
13:44:37 19 THE COMMISSIONER: Who would say  
13:44:38 20 such a thing?  
13:44:42 21 MR. SCOTT: I just felt a vibe  
13:44:42 22 in the room, Your Honour.  
13:44:43 23 But in any event, I would  
13:44:44 24 request an additional hour for  
13:44:46 25 the coming week.  
13:44:47 26 THE COMMISSIONER: Have you  
13:44:48 27 talked to Commission Counsel?  
13:44:50 28 Do they feel that we can  
13:44:52 29 accommodate this?  
13:44:52 30 MS. STEPHENS: Yes. We had a  
13:44:53 31 conversation about this earlier,  
13:44:54 32 and I certainly think that it's

1 clear Mr. Scott has an interest  
2 in that stage of -- the stage of  
3 our evidence in a way that  
4 I think very few other people in  
5 the room have indicated they do.

6 I expect -- as you can see,  
7 the room has gotten light. I  
8 think that's, in part, a  
9 Friday-afternoon issue, but I  
10 don't think we will have that  
11 many parties sticking around for  
12 that part, and I certainly think  
13 it would be appropriate for  
14 Mr. Scott to get that additional  
15 hour.

16 And I believe we'll have no  
17 problem accommodating those four  
18 witnesses next week.

19 THE COMMISSIONER: I don't have  
20 any problem for two reasons:  
21 One, given the client base you  
22 have, it's important that you  
23 have that opportunity.

24 Secondly, it is such a  
25 different area, but still one of  
26 the victims is within the scope  
27 of the inquiry, and we need some  
28 probing, and at least I need the  
29 assurance that the opportunity  
30 for probing in that area has  
31 been extended to the  
32 participants, so I have no

13:45:54 1 problem with that.

13:45:55 2 MR. SCOTT: Thank you,

13:45:56 3 Commissioner.

13:45:57 4 MS. STEPHENS: So, Commissioner,

13:46:00 5 I think that completes what we

13:46:02 6 have for this week. I will give

13:46:05 7 you an idea going into next week

13:46:07 8 where we're at.

13:46:08 9 THE COMMISSIONER: All right.

13:46:09 10 MS. STEPHENS: We have -- the

13:46:11 11 participants have all been very

13:46:14 12 helpful in working towards

13:46:15 13 agreements with respect to which

13:46:17 14 witnesses we actually need here

13:46:18 15 and which we don't.

13:46:20 16 So next week, we'll be

13:46:22 17 tendering the Affidavits of two

13:46:23 18 witnesses who will not be coming

13:46:25 19 to provide viva voce evidence.

13:46:28 20 That will be Aislinn McNally,

13:46:32 21 who is a triage inspector at

13:46:33 22 CIATT, and then it will also be

13:46:35 23 Karen Mitchell, who's a care

13:46:38 24 coordinator at the Southwest --

13:46:39 25 now the Southwest LHIN, formerly

13:46:42 26 of the Southwest CCAC. So that

13:46:46 27 will go in by Affidavit only.

13:46:49 28 The other witnesses who will

13:46:50 29 be attending will be Mr. Philip

13:46:56 30 Moorman. He will be our first

13:46:56 31 witness on Tuesday morning. And

13:46:56 32 then we will have Karin



1 Fairchild, the manager of the  
2 Hamilton SAO.

3 Everyone has had copies of  
4 their Affidavits: Karin's as of  
5 Tuesday, Mr. Moorman's as of  
6 sometime last week.

7 And that will complete the  
8 portion in relation to the  
9 long-term care homes and that  
10 regime governing that.

11 We will then move on to the  
12 two witnesses in relation to the  
13 oversight of the provision of  
14 home care.

15 That will be Donna Ladouceur,  
16 currently of the Southwest LHIN,  
17 formerly the Southwest CCAC, and  
18 then also Steven Carswell, also  
19 with the Southwest LHIN at this  
20 point.

21 So that's where we're at. We  
22 feel very good about what we  
23 managed to make it through this  
24 week, and we are very confident  
25 we'll certainly be able to fit  
26 that into the four days next  
27 week. So that wraps things up  
28 for this week.

29 Before we conclude, I do have  
30 one thing I would like to say.  
31 I've had three members of my  
32 team come back this week to help

13:48:02 1 us out, as you know,  
13:48:03 2 Commissioner.

13:48:04 3 Greg Furmaniuk, Etienne  
13:48:09 4 Lacombe, and Sean Pierce were  
13:48:09 5 all very invaluable in pouring  
13:48:11 6 through the many, many, many  
13:48:12 7 documents that we received this  
13:48:14 8 winter and helping put together  
13:48:16 9 the Overview Report.

13:48:17 10 They had left us to go write  
13:48:20 11 the bar admission course, have  
13:48:22 12 come back for this week of the  
13:48:24 13 hearings, and they've been very  
13:48:25 14 helpful to me this week.

13:48:27 15 And they will not be here  
13:48:29 16 next week as they begin their  
13:48:32 17 articles, but I did want to say  
13:48:33 18 a thank you to them.

13:48:34 19 THE COMMISSIONER: Thank you  
13:48:35 20 very much. I think one of the  
13:48:36 21 most salutary things that you  
13:48:38 22 could ever have at the beginning  
13:48:39 23 of your careers as lawyers is to  
13:48:42 24 watch very professional, highly  
13:48:45 25 skilled people at work, and  
13:48:46 26 you've had the benefit of that  
13:48:48 27 in spades from this group.

13:48:50 28 So I'm glad that you're here,  
13:48:52 29 and I'm glad you can see the  
13:48:55 30 value of your work to the  
13:48:56 31 inquiry. So thank you.

13:48:57 32 So thank you very much. It

1 was a very full week, but it was  
2 a very productive week. And,  
3 again, it could not have been  
4 done without the cooperation and  
5 professionalism in this room of  
6 everybody, including everybody  
7 in that tier right in front of  
8 me.

9 So thank you so much. And I  
10 hope that people will have some  
11 time on the weekend not to just  
12 read Affidavits but perhaps get  
13 some sleep, and I'll see you on  
14 Tuesday.

15 Oh, don't forget to clean the  
16 room, right. It's all going to  
17 get cleaned, so you need to take  
18 all papers. Nothing will be  
19 here, or, you know, it will be  
20 open to the public.

21 THE REGISTRAR: This Public  
22 Inquiry is adjourned until  
23 Tuesday at 9:30 a.m.

24 -- ADJOURNED AT 1:49 P.M. --

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REPORTER'S CERTIFICATE

We, DEANA SANTEDICOLA, RPR, CRR, CSR,  
Certified Shorthand Reporter, and  
CARISSA STABBLER, RPR, CSR, Certified Shorthand  
Reporters, do certify:

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

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

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

Dated this 3rd day of August 2018.



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NEESON COURT REPORTING INC.

PER: DEANA SANTEDICOLA, RPR, CRR, CSR  
& CARISSA STABBLER, RPR, CSR

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