The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System

CLOSING SUBMISSIONS to the Public Hearings
on behalf of THE OFFICE OF THE CHIEF CORONER
and THE ONTARIO FORENSIC PATHOLOGY SERVICE

September 20, 2018

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PART I – OVERVIEW

1. The Office of the Chief Coroner ("the OCC") and the Ontario Forensic Pathology Service ("the OFPS") are grateful for the opportunity provided by this public inquiry to examine Ontario's death investigation system, identify and address gaps in the system, and reflect on how aspects of the system might be improved.

2. The OCC and the OFPS together provide death investigation services in Ontario. While every death in a long-term care home must be reported to the OCC, only when certain criteria are met is a local coroner to be contacted immediately. Local coroners will then consider whether the death requires investigation under s. 10 of the *Coroners Act*[1]. Local coroners were only contacted after the deaths of two of Elizabeth Wettlaufer's eight murder victims[2]. One death was investigated[3] and one was not.[4] For a certain period of time[5], if the death was the tenth (or "threshold death") in the home, the coroner was required by policy to investigate the threshold death[6]. One of the threshold deaths that a local coroner investigated was the death of a long-term care resident who had survived a previous assault by Elizabeth Wettlaufer but died later of unrelated causes[7]. The offences of Elizabeth Wettlaufer were not detected by anyone until she confessed.

3. This Public Inquiry provides an opportunity to consider whether improvements can be made to the system for reporting and investigating deaths in long-term care homes so that the

[1] *Coroners Act*, RSO 1990, c C.37, Tab 2-1, Legislative Brief, Ex. 4, FD0000005.
[2] Arpad Horvath, a resident of MP and one of Elizabeth Wettlaufer's murder victims died after being transferred to hospital and accordingly, there was no requirement to report his death to the Office of the Chief Coroner.
[3] The death of James Silcox
[4] The death of Maureen Pickering
[5] Between March 1, 1995 and September 16, 2013
[6] "Business Case: Transformation – Reduction in Long-Term Care Facility Threshold Death Investigations", Ex. 7, Overview Report: Office of the Chief Coroner and the Ontario Forensic Pathology Service, Tab D, LTCI00069303.
[7] The death of Wayne Hedges

death investigation service is engaged appropriately, including, whether the systems in place are adequate to ensure that all appropriate cases are being investigated and that the investigations are high quality such that the findings can inform the public and assist stakeholders in preventing further deaths.

4. It is important to think broadly when considering recommendations to inform policies that will apply to the death investigation service. The focus of the recommendations should not be narrowly construed to only apply to deaths in long-term care homes, rather the recommendations should apply more broadly to the decision making process of whether to investigate any death and how deaths are investigated. To respond to this challenge too narrowly, focussing only on identifying healthcare practitioners who might be serial killers or controlling the storage and dispensing of specific medications, would be a missed opportunity and could even result in the development of harmful or ineffective policies. Dr. Michael Pollanen, Ontario's Chief Forensic Pathologist and Deputy Chief Coroner, testified that one of the methodological flaws in research in the area of secret homicides[8] is to become overly influenced by a single case or group of deaths caused by a single perpetrator. He states this should be avoided because policy development should not be overly determined by a single rare event[9].

5. The Inquiry into Pediatric Forensic Pathology (the "Goudge Inquiry") found that "thinking dirty" or assuming intentional wrongdoing at the outset of investigating a harm is the wrong

[8] "Secret homicide" is language defined by Mr. Justice A. Campbell in the "Bernardo Investigation Review". Justice Campbell defines secret homicide as the killing of a person that is not readily apparent at the onset of the death investigation but is eventually detected. Dr. Pollanen adopted this definition in his review of secret homicides.

[9] "The Forensic Pathology of Secret Homicides" by Dr. Michael Pollanen, Ex. 118, p. 3, LTCI00072867; It is submitted that the phenomenon of healthcare serial killers is much more rare than Professor B. Yorker suggested as she admittedly did not know how many health care workers there were in the 25 countries surveyed which information would be necessary to calculate the risk of being killed by a healthcare serial killer. Testimony of B. Yorker, Day 35, p.185, lines 16-32 to p. 187 lines 3-7

approach.[10] In fact, this approach was often the precipitating factor leading to wrongful convictions and devastating consequences. We urge the adoption of a broad, open-minded approach when exploring what can be done to increase the safety and security of residents in the long-term care system. A less defined approach could offer broader protections not only to the vulnerable residents of long-term care homes, but also from other likely prevalent risks such as elder abuse, inadequate or negligent medical care and resident on resident assaults.

6. The Goudge Inquiry lead to the creation of the OFPS, which works in tandem with the OCC to provide an integrated death investigation system in Ontario. This Public Inquiry creates an opportunity, ten years after the Goudge inquiry, to further evolve the death investigation system in Ontario by creating a new service delivery model whereby death investigations are conducted by a smaller cadre of highly trained coroners that can facilitate earlier involvement of forensic pathologists in the appropriate death investigations. The Goudge Inquiry also recommended, and Dr. Pollanen has testified, that the involvement of forensic pathologists has been a common factor in detecting secret homicides[11].

PART II - THE FACTS RELATING TO THE DEATH INVESTIGATION SYSTEM

7. Coroners are medical doctors with specialized death investigation training who are appointed to investigate deaths as mandated by the *Coroners Act*.[12] Pathologists are specialized medical doctors who have undertaken postgraduate medical training in pathology[13]. Forensic pathologists have undertaken additional postgraduate training in forensic pathology, which is the application of medicine and science to legal issues, usually in the context of sudden death[14].

[10] Goudge Report Executive Summary, released October 1, 2008, p. 33.
[11] The Forensic Pathology of Secret Homicides" by Dr. Michael Pollanen, Ex. 118 p. 2, LTCI00072867.
[12] Testimony of Dr. Huyer - Day 18, p. 4141, lines 10-12 and p. 4307, lines 6-7.
[13] Testimony of Dr. Huyer - Day 18, p. 4144, lines 5-18.
[14] Testimony of Dr. Huyer - Day 18, p. 4144, lines 19-22.

Forensic pathologists assist in the interpretation of post-mortem findings of medico-legal significance[15].

a) Statutory framework for investigations undertaken by the coroner under the *Coroners Act*

8. The overall scheme of the *Coroners Act* confers a mandate on the Chief Coroner and coroners to act in the broader public interest[16]. The OCC serves the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help inform efforts to improve public safety and prevent further deaths.

9. The duties of the Chief Coroner are set out in section 4 of the Act as it was in force at the time of Elizabeth Wettlaufer's offences (section 3 in the amended Act). The Chief Coroner is responsible for administering the Act and its regulations and supervising all coroners in Ontario in the performance of their duties. Regional Coroners are appointed under section 4 of the Act. They assist the Chief Coroner in the performance of his or her duties in their designated region and are required to perform such other duties as are assigned to them by the Chief Coroner.

10. A death investigation is a process whereby a coroner seeks to understand the circumstances of a person's death. A coroner must answer five questions when investigating a death: who (identity of the deceased); when (date of death); where (location of death); how (medical cause of death); and by what means (natural, accident, homicide, suicide or undetermined)[17]. In

[15] Testimony of Dr. Huyer - Day 18, p. 4144, lines 23-27.
[16] See s. 15 (regarding investigations) and s. 20 (regarding inquests) of the *Coroners Act*, RSO 1990, c C.37, Tab 2-1, Legislative Brief, Ex. 4, FD0000005.
[17] Affidavit of Dr. Dirk Huyer, Ex. 98, para 33, AFF000035; Testimony of Dr. Huyer, Day 18, p. 4158, lines 12-32, p. 4159, lines 1-20; *Coroners Act*, RSO 1990, c C.37, Tab 2-1, Legislative Brief, Ex. 4, FD0000005, s.31(1).

addition, the coroner is tasked with identifying issues that may inform recommendations to reduce further deaths.

11. A coroner is called to investigate deaths that appear to be from unnatural causes, natural deaths that occur suddenly and unexpectedly, and in specific circumstances described in section 10(1) of the *Coroners Act*.[18] Section 10(2) of the *Coroners Act* establishes additional circumstances in which deaths must be reported to the coroner, based on the particular setting of the death[19].

12. The coroner must be notified of every death in a long-term care home by the home and if the coroner is of the opinion that the death should be investigated, the coroner shall investigate the circumstances of the death. If as a result of the investigation, the coroner feels an inquest should be held, the coroner shall call an inquest upon the body.[20]

13. During a death investigation, a coroner may obtain information from several sources including, but not limited to family, co-workers, neighbours, doctors, hospital records, police and other emergency service workers. Contact with family members is important for two reasons: family members typically have information that will inform the investigation and contact allows for the coroner to share information about the investigation. In some instances, the coroner will facilitate transport of the deceased person to a hospital or forensic pathology unit for further examination, typically an autopsy[21].

[18] Affidavit of Dr. Dirk Huyer, Ex. 98, para 34, AFF000035.
[19] Affidavit of Dr. Dirk Huyer, Ex. 98, para 36, AFF000035.
[20] *Coroners Act*, RSO 1990, c C.37, Tab 2-1, Legislative Brief, Ex. 4, FD0000005, s. 10(2.1).
[21] *Coroners Act*, RSO 1990, c C.37, Tab 2-1, Legislative Brief, Ex. 4, FD0000005, s. 16(1).

b) The Coroner System – Appointment process and training

14. Until very recently, coroners were appointed by Order-in-Council and would hold their appointment for life[22]. While all coroners are medical doctors, many have different specialities such as family medicine, anaesthesiology etc. and most only dedicate a portion of their practice to death investigation. Depending on when a coroner was appointed, he or she would have received a different amount of formal training (varying from 3-5 days)[23] and although ongoing continuing education in death investigations is encouraged, it is not compulsory. When initially starting to investigate deaths, each coroner is mentored by a Regional Supervising Coroner. The mentorship continues until it is determined that the coroner has met the required standards of a coroner.

15. The experience of coroners varies greatly depending upon the frequency they are called and notified of a death, the number of death investigations conducted, and the range of deaths they investigate[24]. Similarly, a coroner's familiarity with the procedures to be followed when investigating a death varies with potential limitations associated with less experienced coroners or depending on the amount of training received. Currently, Regional Supervising Coroners are available as a resource for any local coroner who has questions[25].

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[22] Affidavit of Dr. Dirk Huyer, Ex. 98, para 17, AFF000035.

[23] Affidavit of Dr. Dirk Huyer, Ex. 98, para 23, AFF000035; Note there was no training course when Dr. Mann was appointed in the 1980s but he attended a two day meeting. See Testimony of Dr. Mann, Day 20, p. 4638, lines 10-22.

[24] Dr. George received 7-8 calls from Central Dispatch a month, of which 3-4 would result in a death investigation (36-48 annually). See Testimony of Dr. George, Day 20, p. 4682, lines 15-23; Dr. Urbantke estimated she did an average of 50 death investigations per year but that has declined in the past few years with her taking on extra roles in administration. See Testimony of Dr. Urbantke, Day 21, p. 4816, line 19 and p. 4817, line 4. Dr. Urbantke was unable to estimate the number of calls she received from Provincial Dispatch where she declined to investigate because the number was quite variable. See Testimony of Dr. Urbantke, Day 21, p. 4818, lines 2-10. Dr. Huyer conducted 450-500 death investigations annually when working as a full-time Coroner. Testimony of Dr. Huyer, Day 18, p. 4136, lines 31-32 to p. 4137 line 1-5.

[25] Affidavit of Dr. Mann, Ex. 104, para 9a; AFF00036; Testimony of Dr. George, Day 20, p. 4663, lines 1-7.

16. A comprehensive contractual arrangement with clearly defined and measureable performance expectations to effectively institute performance management processes and, where necessary, to terminate the services of the coroner is currently lacking. If there were a contractual relationship with coroners, the terms required to have competency based coroners could be set out in the agreement and the contract terminated in the event that the terms were not fulfilled[26].

17. Recent amendments to the *Coroners Act* permitted the Chief Coroner to appoint 32 coroners for the first time without an Order-In-Council. Work is planned to define contracts that will set out the terms needed to ensure competency based coroners are retained to respond to reports of deaths, make a decision if the death needs to be investigated, investigate the death if necessary and involve the forensic pathology services, if warranted. The Goudge Inquiry found, and Dr. Pollanen has also testified, that the involvement of forensic pathologists has been a common factor in detecting secret homicides[27].

18. Dr. Huyer, the Chief Coroner, envisions a role for a cadre of competency based trained coroners who have committed to dedicating a significant proportion of their professional careers to death investigation. These competency based coroners would integrate death investigations into their professional practices, working to gain more experience investigating a wide variety and higher volume of deaths. It would be an expectation for these coroners to participate in continuing education regarding death investigation. In addition, coroners would take the time to analyze trends and share information with those in a position to lead change so that measures could be taken to inform the prevention of further deaths.

[26] Testimony of Dr. Huyer, Day 19, p. 4358, lines 28-32, p. 4359, lines 1-30.
[27] The Forensic Pathology of Secret Homicides" by Dr. Michael Pollanen, Ex. 118, p. 2, LTCI00072867

19. The OCC and OFPS have been working to increase the volume of death investigation teaching in medical schools[28].

c) Reporting of Long-term Care home deaths to the coroner

20. Approximately 20,000 residents die in long-term care homes annually[29]. All of these deaths are reported to the coroner as required by s. 10(2.1) of the *Coroners Act.* Deaths are currently reported to the coroner using an Institutional Patient Death Record ("IPDR"). The IPDR form contains a series of questions that attempt to elicit the circumstances where a coroner will potentially need to investigate a death. If any of these questions are answered "Yes", the local coroner has to be called immediately[30]. The coroner evaluates the information provided by the long-term care staff and determines whether the case needs to be investigated.

21. A number of witnesses were asked whether they understood how to answer the question on the IPDR form inquiring about whether a death was "sudden and unexpected". Some felt comfortable answering this question[31] and knew they could seek advice from the OCC if they wished clarification. In fact, the minutes from a weekly meeting of nursing staff at Caressant Care - Woodstock[32] support that staff were trained in considerable detail on how to determine if a death was "sudden and unexpected". Other witnesses did not understand the question as well[33].

[28] Affidavit of Dr. Dirk Huyer, Ex. 98, para 29, AFF000035;Testimony of Dr. Huyer, Day 18, p. 4161, lines 13-32, p. 4162, lines 1-21.
[29] Testimony of Dr. Hillmer, Day 37, p. 8429, lines 29-32 to p. 8430, lines 1-16.
[30] Since the implementation of Provincial Dispatch between September 2011 and the Spring of 2012, the death is reported by calling Provincial Dispatch, who will arrange for a coroner to call the person reporting the death.
[31] Testimony of Helen Crombez, Day 6, p. 1200, lines 14-24; Testimony of Karen Routledge, Day 6, p. 1355, line 32, p. 1356, lines 1-22.
[32] Registered Staff Meeting Minutes, dated March 25, 2014, Ex. 23, p. 2, LTCI00072134
[33] Laura Long testified that she had no training in the meaning of "sudden and unexpected". She described an occasion where she reported the death as "sudden and unexpected" and was later told by a doctor that the death was not unexpected, Testimony of Laura Long, Day 9, p. 1945, lines 2 -32, p. 1946, lines 1-18.

22. Dr. Huyer testified that work is underway to revise the IPDR form to contain more evidence-based questions[34] to better ensure that cases that should be investigated by a coroner are not missed because they are not reported to the coroner. Dr. Huyer envisions that the revised form would be completed by the medical practitioner responsible for the resident's care[35] and therefore would be in a better position to provide accurate information in response to questions on the form and in particular whether the death would meet the criteria of "sudden and unexpected" within the meaning of the *Coroners Act*. It is contemplated that additional training should be provided to those completing the revised IPDR[36].

23. In addition, although the IPDR is required to be submitted electronically, about 8% of the forms continue to be faxed to the Office of the Chief Coroner.[37] If total compliance with electronic submission of the forms could be achieved, there would be opportunities to better analyze trends and patterns within institutions or regions.

d) Whether to investigate a death

Communications with Provincial Dispatch

24. Beginning in September 2011 and continuing until the spring 2012, stepwise rollout of a Provincial Dispatch system for reporting deaths to the Office of the Chief Coroner took place whereupon a local coroner would be contacted by Provincial Dispatch with notification about a reported death[38]. This was a positive development that allowed for consistency in terms of where to report a death and the presence of trained persons to take information about the death to pass onto the local coroner. Ms. Pickering's death was reported to Provincial Dispatch and based

[34] Affidavit of Dr. Dirk Huyer, Ex. 98, para 120, AFF000035; Ex HH to the Affidavit of Dr. Dirk Huyer, "Resident Death Screening Tool", LTCI00071448.
[35] Affidavit of Dr. Dirk Huyer, Ex. 98, para 122(a), AFF000035.
[36] Affidavit of Dr. Dirk Huyer, Ex. 98, para 121, AFF000035.
[37] Affidavit of Dr. Dirk Huyer, Ex. 98, para 99, AFF000035.
[38] Affidavit of Dr. Dirk Huyer, Ex. 98, para 50, AFF000035.

on the evidence of Noelle Kelly, any information communicated to her was passed on to the assigned local coroner, to allow consideration of whether the case needed to be investigated[39]. The local coroner is expected to speak with the person who contacted Provincial Dispatch making the initial report.

Access to Records

25. We heard evidence from local coroners that at the stage of considering whether to investigate a death, they rely upon information voluntarily provided to them from various sources. These sources include persons at the scene of death, such as police or witnesses, the deceased's treating doctor or treating emergency room physician, or long-term care staff as well as information from the family or friends of the deceased[40]. The coroner does not have the statutory power to compel or review medical or other records until a decision is made that the case meets the criteria under s. 10 of the *Coroners Act* for a death investigation to be conducted[41].

The decision whether to investigate

26. Part of the continuing education into death investigations that Dr. Urbantke received included a case study involving a medication error where the wrong patient received a dose of insulin. This training led to her being concerned, albeit in the context of her role as treating physician in the emergency room, about Ms. Pickering's unexplained low blood sugar[42]. As a result, she noted in Ms. Pickering's medical record that this is a case that should be reported to the coroner when Maureen Pickering died[43]. In addition, she telephoned the long-term care home

[39] Affidavit of Noelle Kelly, Ex. 97, para. 5, AFF00018
[40] Testimony of Dr. Urbantke, Day 21, p. 4883, lines 29-32, p. 4884, lines 1-11.
[41] *Coroners Act*, RSO 1990, c C.37, Tab 2-1, Legislative Brief, Ex. 4, FD0000005, s.16(2).
[42] Testimony of Dr. Urbantke, Day 21, p. 4878, lines 4-32 and p. 4879, lines 1-22.
[43] Testimony of Dr. Urbantke, Day 21, p. 4864, lines 9-28.

to instruct nursing staff to do so[44]. As a result of these instructions, nurse Karen Routledge contacted Provincial Dispatch to report the death of Maureen Pickering to the OCC[45].

27. Dr. Urbantke was not the coroner who determined whether to investigate Ms. Pickering's case. Having recently treated Ms. Pickering, it would have been a conflict of interest for her to do so. However, the concern that she raised demonstrates how education of local coroners can have a positive impact on making sure the appropriate cases get investigated. Where there is a possible medication error that may have caused a death, it would be in the public interest to investigate the death.

28. The OCC and OFPS acknowledge that the death of Maureen Pickering was a missed opportunity to be investigated and to involve forensic pathology at an early stage[46], not because it was suspected that she was murdered by a healthcare serial killer but because there were unanswered questions that would have provided opportunity to identify the precipitating factors and allowed further analysis. It is hoped that competency based trained coroners with sufficient training and experience would not only investigate this case type but involve the forensic pathologist in the investigation. The fact that a medical practitioner was sufficiently concerned about unexplained hypoglycemia before Ms. Pickering's death to indicate that a coroner should be called upon the patient's death and the fact that the cause of the hypoglycemia in a non-diabetic person remained unexplained warranted death investigation and the assistance of a forensic pathologist to help determine the cause and inform the manner of Ms. Pickering's death.

[44] Testimony of Dr. Urbantke, Day 21, p. 4881, lines 5-23.
[45] Karen Routledge agreed that she called Provincial Dispatch at 8:28 am, notified Dr. Reddick at 9:25 am, submitted the IPDR form at 9:30 am (which was received by the OCC at 9:35 am), Dr. George called back at 9:50 am and Dr. Reddick came in to pronounce the death at 10:35 am. See Testimony of K. Routledge, Day 7, p. 1409 line 19 to p.1414, line 13; Affidavit of Noelle Kelly, para 5(a), AFF000018, Ex.97
[46] Testimony of Dr. Pollanen, Day 22, p. 5108, lines 19-21.

29. Ontario submits that even if Ms. Pickering's death was investigated and a post mortem examination requested, it is not clear that her homicide would have been detected[47]. Toxicological testing at the Centre of Forensic Sciences (CFS) is not routinely ordered following all deaths nor would it be practical to do so[48]. If toxicology tests are ordered by a forensic pathologist, the testing requested is tailored depending on the circumstances of the case[49]. Insulin is not a "toxin" and would not form part of toxicological testing[50]. Testing for insulin post mortem is fraught with difficulty.[51] The CFS currently does not have the means to test for insulin and Dr. Pollanen and Dr. Huyer are not aware of a laboratory in Ontario that could do so[52]. Blood sugar levels cannot be accurately tested after death and even if they could be tested by taking samples from certain parts of the body immediately post death, they would not provide meaningful readings[53].

30. As. Dr. Pollanen explained, in the case of Maureen Pickering an examination of the brain by a neuropathologist would have been ordered that likely would have confirmed hypoglycemic brain damage[54]. Thereafter, the coroner would have systematically worked to analyze what caused the brain damage which may have led to considerations such as medication error or intentional harm[55].

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[47] Testimony of Dr. Pollanen, Day 22, p.5109, lines 2-32 to p. 5110, line 105.
[48] Affidavit of Dr. Michael Pollanen, Ex. 116, para 107(a), AFF000037.
[49] Affidavit of Dr. Dirk Huyer, Ex. 98, para 70, AFF000035; Affidavit of Dr. Pollanen, Ex. 116, para 107(a), AFF000037.
[50] Affidavit of Dr. Michael Pollanen, Ex. 116, para 105, AFF000037.
[51] Affidavit of Dr. Michael Pollanen, Ex. 116, para 107(c) - (e), AFF000037, Dr. Huyer testified that they would not be able to find insulin post death as there is no testing capacity in Ontario, Testimony of Dr. Huyer, Day 19, p.4439, lines 19 -32 to p. 4440, lines 1-10.
[52] Affidavit of Dr. Michael Pollanen, Ex. 116, para 105-6, 107(b), AFF000037, see reference to Dr. Huyer testimony, supra
[53] Affidavit of Dr. Michael Pollanen, Ex. 116, para 104, AFF000037.
[54] Testimony of Dr. Pollanen, Day 22, p. 5059, lines 24-28.
[55] Testimony of Dr. Pollanen, Day 22, p. 5108, lines 10-14.

e) The Investigation

Quality of the investigation

31. There is no evidence that the investigation into the death of James Silcox was not done in accordance with the standard of care required of a local coroner. James Silcox died on August 10, 2007 after having an accidental fall on July 31, 2007 and undergoing surgery for a hip fracture on August 4, 2007. Dr. George examined the body[56] and the deceased's medical records[57] and indicated he had discussed the death with his family and they had no concerns[58]. Dr. Huyer explained that a local coroner must determine the cause of death with a degree of certainty that is "on the balance of probabilities.[59] In other words, Dr. Huyer testified the coroner determines the most likely cause of death[60].

32. Dr. George indicated that based on his review of Mr. Silcox' medical records, James Silcox had several co-morbidities[61] . Dr. George concluded, on the balance of probabilities (or in other words, it was very likely) that the cause of Mr. Silcox' death was complications from his hip fracture which is a very traumatic event for an elderly person.[62] A coroner would only consult a forensic pathologist and/or request a post mortem where the coroner cannot determine the cause of death on the balance of probabilities[63]. Although James Silcox had an episode of low blood sugar reading of 1.8 on August 10, 2007 at 21:37, two days before his death, it was not anything

[56] Testimony of Dr. George, Day 20, p.4643, line 2-21
[57] Testimony of Dr. George, Day 20, CCW progress notes p.4712 line 22 to p. 4716 line 5, hospital records p. 1417 line 10 to p. 4718 line 12; LTCI0004770
[58] Testimony of Dr. George, Day, 20 p. 4721 line 5 to p. 4723 line10
[59] Affidavit of Dr. Dirk Huyer, Ex. 98, para 84, AFF000035.
[60] Testimony of Dr. Huyer, Day 18, p. 4286, lines 7-28.
[61] Including a history of Alzheimer's dementia, Diabetes – insulin dependent, hypertension and cerebrovascular disease – previous history of cerebrovascular accident, reflux and dyslipidemia. See CIS Statement for James Silcox, LTCI00065227
[62] Testimony of Dr. George, Day 20 p. 4703, line 27-32 to p 4704 lines 1-16; p. 4723 line 11-32 to p. 4724 lines 1-26; LTCI0004711
[63] Testimony of Dr. George, Day 20, p. 4702 line 30-32 to p.4703, line 1-7; Testimony of Dr. Huyer, Day 18, p. 4275, lines 2-29.

unusual for a diabetic on a mix of rapid and longer-acting insulin to have a single episode of low blood sugar.[64]

33. Dr. George completed a Coroner's Investigation Statement or Form 3 following the investigation into James Silcox' death which was reviewed and approved by a Regional Supervising Coroner on March 6, 2008.[65] Dr. Mann testified that had he reviewed this CIS Form at the time, in the normal course of approving and signing off on CIS statements, he would not have had any concerns[66].

Input from families

34. There was evidence from Dianne Crawford, the daughter of James Silcox, that she did not know how to express her concerns about what caused the death of her father. She asked the nurse caring for her father for advice. The nurse in question was Ms. Wettlaufer, who provided Ms. Crawford with the inaccurate advice to call the coroner in 4-6 weeks, a period of time she likely knew was too long to allow for a meaningful death investigation[67]. Coroners currently are expected to provide information about the investigation findings to families supplemented by way of a pamphlet or by referring families to the OCC website[68].

35. Coroners do routinely seek to speak to family members of the deceased who can often provide valuable information about the circumstances of the death, the deceased's prior health and advise if there have been any concerns about medical care provided to the deceased, for

[64] Testimony of Dr. George, Day 20, p. 4716, lines 19-32 to p. 4717, lines 1-9; CCW Progress notes, LTCI00004711 referenced in the Facilities Overview Report, Ex. 6, c. 5(iii), para. 38
[65] As per the "QA -06/Mar/2008" on the bottom of the CIS form Document LTCI00065227, See Affidavit of Dr. G. Richard Mann, Ex. 104, AFF000036, and Ex. I. thereto.
[66] Testimony of Dr. Mann, Day 20, p.4614, lines 22-30
[67] Affidavit of Dianne Crawford, Ex. 115, AFF000039, paras. 7-8.
[68] Testimony of Dr. George, Day 20, p. 4649, lines 15-23

example[69]. Dr. George noted in his Coroner's Investigation Statement following the death of James Silcox that "His death was discussed with his family; they had no concerns."[70] It was also his practice that if he discussed the matter with the family more than once he would so indicate on the Form 3[71]. Dianne Crawford, daughter of James Silcox and his power of attorney stated in her Affidavit that she and her family did not have any discussion with the coroner on the day her father died[72]. Unfortunately, Dr. George did not maintain any notes he took from his investigation into James Silcox' death. We did hear evidence that the names of family members spoken to would be something that should not be included in the narrative of the CIS Statement. For the last 6-7 years, Dr. George has changed his practice to describe the relationship of the family member to whom he spoke with the deceased as part of his narrative.[73]

36. Dr. Urbantke similarly noted that the "Family had no concerns" when investigating the death of Wayne Hedges.[74]

Post Mortem examinations

37. Both the Chief Coroner and the Chief Forensic Pathologist support the greater integration and earlier involvement of forensic pathology in death investigations. Competency based trained coroners will be better equipped to involve and consult with forensic pathologists and/or request post mortems in cases that warrant it.[75] Forensic pathologists, during the course of an autopsy

[69] Testimony of Dr. George, Day 20, p.4696 line 27 – p. 4699, line 13; Testimony of Dr. Urbantke, Day 21, p. 4834, lines 25-32 and p. 4835, lines 1-14.
[70] James Silcox CIS Statement – (CIS 2007-11982), LTCHI00065227. p. 1.
[71] Testimony of Dr. George, Day 20, p.4701, lines 11-22
[72] Affidavit of Dianne Crawford, Ex 115, AFF000039, paras 9-10.
[73] Testimony of Dr. George, Day 20, p. 4700, 2-25
[74] Testimony of Dr. Urbantke, Day 21, p. 4855, line 11-18.
[75] Affidavit of Dr. Dirk Huyer, Ex. 98, para 69, AFF000035.

have been able to discover subtle injuries. Secondly, forensic pathologists can interpret the significance of injuries[76].

38. The fact that less post mortems are ordered following the death of elderly persons[77] is not unusual since elderly persons are more likely to suffer from various medical conditions and there are more plausible explanations for their deaths. There is no evidence that post mortem examination was warranted in the investigation into the deaths of James Silcox or Wayne Hedges. In the case of James Silcox, the medical cause of his death, based on the information known at the time, was "Complications of Fractured Right Hip" with contributing factors of "Alzheimer's, Diabetes, Cerebrovascular Disease"[78]. It is with the benefit of hindsight, and with the acceptance of Ms. Wettlaufer's confession that the death was retrospectively attributed to intentional homicide by way of insulin[79].

39. The death of Wayne Hedges was determined by Dr. Urbantke to be caused by cerebral vascular accident. Dr. Urbantke described what lead her to that conclusion, none of which required a post mortem examination[80].

40. Dr. Pollanen testified that one initiative that the OFPS is considering developing is a specific protocol for the medico-legal autopsies conducted in the elderly population, like the protocol that exists for persons under five years old[81]. Such an endeavour could ensure that

[76] The Forensic Pathology of Secret Homicides" by Dr. Michael Pollanen, Ex. 118, p. 13, LTCI00072867.
[77] Dr. Huyer testified that autopsies are included in 40-45% of the cases investigated. See Testimony of Dr. Huyer, Day 18, p. 4158, lines 3-11; Dr. Huyer also testified that post mortem exams are infrequent in long-term care homes. Testimony of Dr. Huyer, Day 18, p. 4139, lines 26-32 to p. 4140, line 1-2.
[78] CIS Statement, Document LTCI00065227, See Affidavit of Dr. G. Richard Mann, Ex. 104, AFF000036 and Ex. I thereto.
[79] Retrospective CIS completed by Dr. Huyer, Exhibit NN to the Affidavit of Dr. Dirk Huyer, Ex. 98, AFF000035.
[80] Testimony of Dr. Urbantke, Day,21 p.4853, lines 22-32 and p. 4854, lines 1-6; CIS for Wayne Hedges, Ex. LL to the Affidavit of Dr. Dirk Huyer, Ex. 98, AFF000035.
[81] Affidavit of Dr. Michael Pollanen, Ex 116, para 139, AFF000037; Testimony of Dr. Pollanen, p.5142, lines 11-32 to p. 5144, lines 1-9.

information gathered during the autopsy would increase the likelihood of discovering issues such as abuse or negligent care of the elderly.

Threshold Investigations

41. There is no evidence that the death investigation system would benefit from having the coroner return to conducting death investigations for every tenth death in a long-term care home. Historically, every death in a nursing home was investigated and in 1995, a decision was made to investigate only every tenth death[82]. As of September 16, 2013, a decision was made to no longer investigate threshold deaths[83]. Part of the rationale was that it was not a good use of resources to investigate every tenth death in a home[84]. There is little evidence to suggest that such investigations were beneficial.[85] For example, the death of Wayne Hedges was investigated as a threshold death by Dr. Urbantke. Dr. Urbantke determined the cause of Wayne Hedge's death to be a cerebral vascular accident[86].

42. Investigating threshold deaths did allow an investigating coroner to look at the death registry and identify any previous deaths that should have been investigated but were not[87]. However, this can still be done today by any coroner investigating any death in a long-term care home even though the death registries typically contain limited information making it challenging to effectively review these deaths.

43. Given that investigating every tenth death would follow a predictable pattern, it would not act as a significant deterrent for anyone in the long-term care homes setting who intends to cause residents harm. With the advancement of technology, Dr. Huyer suggested it would be more

[82] Affidavit of Dr. Dirk Huyer, Ex. 98, para 111, AFF000035.
[83] Affidavit of Dr. Dirk Huyer, Ex. 98, para 112, AFF000035.
[84] Affidavit of Dr. Dirk Huyer, Ex. 98, para 113, AFF000035
[85] Testimony of Dr. Huyer, Day 18, p. 4227, lines 15-32 and p. 4228, lines 1-20.
[86] Testimony of Dr. Urbantke, Day 21, p. 4853, lines 22-32 and p. 4854, lines 1- 6.
[87] Testimony of Dr. Urbantke, Day 21, p. 4828, lines 15-20.

effective to explore the use of data analytics to help identify when there are clusters or an increase in the number of unexpected deaths in a home.[88]

Death Registries in Long-term Care homes

44. Each long-term care home is required to keep a death registry and to record the name of residents who die, the date of death, the cause of death and whether the coroner was contacted[89]. The form used by CCW included a space to put the "Average number of deaths per month in this facility" as well as a range where the lowest number of deaths to the highest number of deaths per month could be inserted[90]. Dr. Urbantke testified that homes did not always provide all the information required for each death in the register and when this issue was identified by her, she would ask the home to complete the death register[91]. It was also apparent that Maureen Pickering's death had not been entered into the death registry[92] as required. In addition, no one entered the average number of deaths per month or the lowest and highest number of deaths per month on any of the pages of the death registry[93].

45. It is submitted that with new technology a better way to record and track the number of deaths in the home could be developed.

f) Oversight

46. Previously, there was no ability to oversee the decision by a coroner not to investigate a case until the case selection data form was created[94]. Although best practice would be to

[88] Testimony of Dr. Huyer, Day 18. p. 4191, lines 16-32 to p. 4192, lines 1-22.
[89] Ex. W to the Affidavit of Dr. Huyer Ex. 98, LTCI00069309-2; Testimony of Dr. Huyer, Day 18, p. 4192, lines 2-32 to p. 4193, lines 1-26.
[90] Ex. 107, LTCI00071970_01-1.
[91] Testimony of Dr. Urbantke, Day 21, p. 4872 lines 7-17.
[92] Testimony of Karen Routledge, Day 6, p. 1358, lines 7-32, referencing LTCI00071978.
[93] Resident Death or Transfer Record for Caressant Care Woodstock, Ex. 107, LTCI00071970_01-1. Agatha Krawczyk testified that the Director of Care would fill this out, Testimony of Agatha Krawczyk, Day 8, p. 1880, lines 10-27.
[94] Affidavit of Dr. G. Richard Mann, Ex. 104, AFF000036, para 19, and LTCI00071436, Ex. B to the Affidavit hereto; Testimony of Dr. Mann, Day 19, p. 4580, lines 4-32 to p. 4581, line 1.

complete this form, it is not consistently completed by coroners[95]. Since the creation of Provincial Dispatch, all decisions not to investigate a death are recorded. Therefore, the Office of the Chief Coroner can track the numbers of cases not investigated by any given coroner[96]. In addition, coroners are expected to document their decision not to investigate in writing to enable auditing and oversight of the rationale behind these decisions[97].

47. A new case management IT solution is currently in the implementation phase at the OCC. One of the expectations will be for a coroner to document the rationale behind their decisions regarding whether to investigate a death in the new system which will make the decision more accessible for review. Review of these decisions will be one of a number of opportunities to evaluate local coroners.

48. Currently Regional Supervising Coroners review every Coroner's Investigation Statement (CIS) prepared to ensure it is accurate, makes sense, and is free of spelling errors or other inappropriate narrative[98]. The CIS Form prepared following the death of Wayne Hedges was reviewed and approved by Regional Supervising Coroner Lucas[99]. Moving to a model where competency based trained coroners are retained on contract will enhance the ability of the Regional Supervising Coroners to oversee the quality of investigations and take corrective actions where a coroner is not performing in accordance with the performance expectations[100].

[95] Affidavit of Dr. G. Richard Mann, Ex. 104, AFF000036, para 19 and LTCI00071436, Ex. B to the Affidavit of Dr. hereto; Testimony of Dr. Mann, Day 19, p. 4581, lines 17-30.
[96] Affidavit of Dr. Dirk Huyer, Ex. 98, paras 50-53, AFF000035.
[97] Affidavit of Dr. Dirk Huyer, Ex. 98, para 63, AFF000035.
[98] Testimony of Dr. Mann, Day 19, p. 4584, lines 10-32 to p. 4587, lines 1-31; Affidavit of Dr. G. Richard Mann, Ex. 104, AFF000036, para 32.
[99] CIS Statement of Wayne Hedges, Doc. LTCI00064920-1
[100] Affidavit of Dr. Dirk Huyer, Ex. 98, para 20, AFF000035; Testimony of Dr. Huyer, Day 18, p. 4307, lines 21-27.

49. In addition, the Death Investigation Oversight Council which was established following the Goudge Inquiry provides oversight of the Chief Coroner for Ontario and the Chief Forensic Pathologist for Ontario.[101]

g) Post Investigation

50. One of the duties of the OCC is to analyze and report on trends arising from death investigation. As indicated by Dr. Huyer, data obtained both individually from death investigation or aggregate data can be analyzed and used by other stakeholders[102]. One example given was that the Ministry of Health and Long-Term Care ("MOHLTC") uses aggregate data to inform strategies in an effort to reduce further opioid deaths.[103] The OCC annual report for 2012-2015 gives examples of other endeavours to analyze trends such which resulted in the release of the Cycling Death review, Pedestrian Death review and Review of the Ornge Air Ambulance Deaths.[104]

51. The OCC also has specialty committees such as the Geriatric and Long-Term Care committee that meets regularly to review cases referred to them by Regional Supervising Coroners[105]. The Geriatric and Long-Term Care Committee makes recommendations to long-term care homes and other stakeholders on issues related to preventing deaths of the elderly both in and outside of long-term care homes. The Committee generates annual reports[106] each of which contains recommendations that were made during the year.

[101] Affidavit of Dr. Dirk Huyer, Ex. 98, para 13, AFF000035.
[102] Testimony of Dr. Huyer, Day 18, p. 4317, lines 25-32 to p. 4319, lines 1-28
[103] Affidavit of Dr. Dirk Huyer, Ex. 98, para 43, AFF000035.
[104] OCC Annual Report 2012-2015, Ex. C, to the Affidavit of Dr. Huyer Ex. 98, p. 17-18 of the Exhibit
[105] Testimony of Dr. Huyer, Day 18, p.4291, lines 2-32; p.4292, lines 1-9.
[106] Testimony of Dr. Huyer, Day 18, p.4292 lines 10-32 to p.4293 lines 1-24.

PART III – SUMMARY AND RECOMMENDATIONS

52. In conclusion, Ontario has a uniquely integrated death investigation system that makes use of the best of both the coroner and forensic pathology skill sets. A broad open minded approach should be taken in considering recommendations that can provide protections to not only to residents in long-term care homes but to other vulnerable populations as well. Earlier involvement of forensic pathology in death investigations is a factor that uncovered secret homicides, even outside the long-term care context. The following are possible recommendations for discussion in Phase 2 of the Public Inquiry.

The Coroner system – A new service delivery model

53. Reform of the coroner appointment system and development of a new service delivery model would allow for the appointment of a smaller cadre of dedicated, competency based coroners. This process is currently being explored with the recent appointment of the first coroners who were not appointed by Order in Council[107]. This type of reform will help coroners ensure that the appropriate cases are investigated and high quality investigations are provided.

54. Provincial Dispatch currently allows for the oversight of the frequency with which coroners decline to investigate cases[108]. All investigations are currently overseen by Regional Supervising Coroners[109] and the performance of a smaller cadre of competency based coroners can be more readily and efficiently overseen in the new service delivery model.

[107] Testimony of Dr. Huyer, Day 18, p. 4306, line 21 to p. 4307, line 32.
[108] Affidavit of Dr. Dirk Huyer, Ex. 98, para 52, AFF000035.
[109] Affidavit of Dr. G. Richard Mann, Ex. 104, AFF000036. paras. 27 and 32.

Reporting of deaths in Long-Term Care homes

55. Revising the process for reporting deaths in long-term care will provide coroners with better information in order to decide whether to investigate a death. Ontario submits that the OCC should continue to revise the reporting process including specific focus on revision of the IPDR form to include evidence based questions, develop a policy that would require the medical practitioner most responsible for the resident's care to complete the IPDR form and train these individuals in the completion of the form and reporting to local coroners.

Greater powers when deciding to investigate

56. Given that we consistently heard that a deceased's medical history is an important factor in determining whether a death was "sudden and unexpected" and therefore needed to be investigated, there would be real value if a coroner could exercise greater power and be granted consistent access to the deceased person's medical records, at the initial stage of deciding whether to investigate.

Earlier involvement of forensic pathologist

57. Under the new service delivery model, competency based coroners will have a better understanding of the importance and benefit of involving a forensic pathologist earlier in investigations and gain from the forensic pathology expertise in this area. Earlier involvement of forensic pathologists has been a factor in detecting secret homicides.

Post Mortem examinations

58. Developing a protocol for medico-legal autopsies conducted in the elderly population will increase the likelihood that any harm, not only from a potential healthcare serial killer, but from

more prevalent concerns such as elder abuse and possible inadequate or negligent care is identified.[110]

Revise compensation for death investigators

59. It is recommended that coroners and forensic pathologists be paid commensurate with the time spent in considering whether to investigate a death or during the investigation of a death. This would lead to better decisions, documentation and opportunity for review[111].

60. Currently coroners are paid a fee of $30 for the service of considering whether to investigate a death during the daytime and $60 for a decision at night time[112]. Dr. Huyer testified that in most cases Coroner do not complete the Case Selection form and invoice because it is not worth the effort to submit a request for payment even though the form would simultaneously involve documenting the rationale for not investigating[113].

61. The time to investigate any death can vary greatly depending on the circumstances. Currently coroners are paid a fee for service of $450 per death investigation but have the ability to apply to the Regional Supervising Coroner for an increase in pay if more than three hours were spent on the investigation[114].

[110] Testimony of Dr. Pollanen, Day 22, p.5154, lines 7-32 to p. 5155, lines 1-26.
[111] Testimony of Dr. Huyer, Day 18, p. 4308, lines 1-13.
[112] Affidavit of Dr. Dirk Huyer, Ex. 98, para 88, AFF000035
[113] Testimony of Dr. Huyer, p.4258, lines 22-32 to p. 4259 lines 1-6; Dr. George understood the form needed to be submitted if the Coroner wanted to be reimbursed, Testimony of Dr. George, Day 20, p. 4675, line 29-32 to p. 4676, lines 1-24; Dr. Urbantke infrequently submitted them since the creation of Provincial Dispatch since she thought the purpose of the form was to track the number of declined cases which Provincial Dispatch now does. Testimony of Dr. Urbantke, Day, 21, p. 4826, lines 7-30.
[114] Affidavit of Dr. Dirk Huyer, Ex. 98, para 87, AFF000035; Testimony of Dr. Huyer, Day 18, p. 4155, lines 6-12.

Identifying clusters or increased numbers of deaths and the role of the death investigation system

62. Dr. Michael Hillmer, Executive Director of Information Management, Data and Analytics within the Health System Information Management Division of the MOHLTC, at the request of the Assistant Deputy Minister of Health, supervised the creation of a model to see if any unusual cluster of deaths at the time and place of Ms. Wettlaufer's offences could have been detected using data that is available to the MOHLTC. Dr. Michael Hillmer's team created a preliminary model that sought to predict the number of deaths expected in a long-term care home, based on the characteristics of its residents and compared that to the number of observed deaths over a given period to arrive at a standardized mortality ratio for each home. In this way, any homes with more deaths than expected could be identified and compared[115]. There are some pros and cons of the model[116]. In particular, a death in a small home could significantly change a small home's ranking upward. The model showed that CCW, where 7 of the 8 murders occurred was ranked in the top 10% of long-term care homes or roughly 63rd when data was run around the times of the offences[117].

63. Whether or not such information is of practical use warrants further discussion. Would it be feasible to go into a number of long-term homes with higher rates of mortality than expected and look more closely at the causes of death? About 20% of residents in long-term care die every year[118]. The data period over which to calculate the standardized mortality ratio is recommended to be one year. This means that in one large home, with 300 residents, approximately 50 deaths may have occurred over the year that would have to be looked at more closely. It was Dr.

[115] Affidavit of Dr. Michael Hillmer, Ex. 168, para. 25, AFF000049.
[116] Affidavit of Dr. Michael Hillmer, Ex. 168, para. 49, AFF000049.
[117] Affidavit of Dr. Michael Hillmer. Ex. 168, para. 63, AFF000049.
[118] Testimony of Dr. Hillmer, Day 37, p. 8429, lines 29-32 to p. 8430, lines 1-16.

Huyer's evidence that any action taken in response to the detection of homes with excessive mortality rates would require a multidisciplinary team that includes the coroner[119].

64. Alternatively, is it possible that the information could be used to assist the coroner in determining whether a particular death in a home should be investigated. These are questions that the OCC suggests be discussed at Phase 2 of the Public Inquiry.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

September 20, 2018

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[119] Affidavit of Dr. Dirk Huyer, Ex. 98, para 122(b), AFF000035.