

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

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DAY 24/VOLUME 24  
July 25, 2018

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77 King Street West, Suite 2020  
Toronto, ON M5K 1A2  
1.888.525.6666 | 416.413.7755

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

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--- This is Day 24/Volume 24 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 25th day of July, 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  
& Olivia Arnaud, CSR

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

Rebecca Jones, Esq.,                      Commission Counsel  
& Laura Robinson, Esq.,

David M. Golden, Esq.,                      Caressant Care  
Nursing and  
Retirement Homes  
Limited, Caressant  
Care - Woodstock

Linda Rothstein, Esq.,                      College of Nurses  
& Denise Cooney, Esq.,  
& Mark Sandler, Esq.,

Paul H. Scott, Esq.,                      Jon Matheson,  
Pat Houde,  
Beverly Bertram

Shaun Singh, Esq.,                      Registered  
Practical Nurses  
Association

Rita Bambers, Esq.,                      Her Majesty the  
Queen in Right of  
Ontario

Nicole Butt, Esq.,                      Ontario Nurses  
& Kate Hughes, Esq.,                      Association

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

Jane Meadus, Esq., Advocacy Centre  
& Suzan E. Fraser, Esq., for the Elderly

Alex Van Kralingen, Esq., Arpad Jr. Horvath,  
& Mark Repath, Esq., Laura Jackson,  
Don Martin,  
Andrea Silcox,  
Adam Silcox-Vanwyk,  
Shannon Lee  
Emmertson,  
Jeffrey Millard,  
Judy Millard,  
Sandra Lee Millard,  
Stanley Henry  
Millard,  
Susie Horvath

Christine Mainville, Esq., Registered Nurses  
Association of  
Ontario

Jared B. Schwartz, Esq., AdvantAge Ontario

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

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1 -- Upon commencing at 9:33 a.m.  
2  
3 MS. JONES: Good morning,  
4 Commissioner.  
5 THE COMMISSIONER: Good morning.  
6 MS. JONES: We will start this  
7 morning with the continuation of  
8 Ms. Coghlan's examination.  
9 THE COMMISSIONER: Yes, thank  
10 you.  
11 THE WITNESS: Good morning.  
12 THE COMMISSIONER: Good morning.  
13 ANNE COGHLAN; Under Prior Oath.  
14 EXAMINATION IN-CHIEF BY MS.  
15 JONES (CONT'D):  
16 Q. Good morning, Ms. Coghlan.  
17 A. Good morning.  
18 Q. I'm going to turn now, Ms.  
19 Coghlan, to 2014 and the receipt of the  
20 Caressant Care Mandatory Report.  
21 A. Yes.  
22 Q. And first I am going to ask a  
23 few questions about the College's process when  
24 it receives a Mandatory Report, so if I can ask  
25 you to turn to page 34 in your affidavit,  
26 please, and at 83 of your affidavit you state  
27 that:  
28 "The initial review [of a  
29 report] is done by an Intake  
30 Investigator."  
31 Correct?  
32 A. That's correct.

1 Q. And here for the Caressant  
2 Care report, that intake review was done by  
3 Karen Yee?

4 A. That's correct.

5 Q. And Ms. Yee, as we will hear,  
6 is both a nurse and a lawyer?

7 A. Yes.

8 Q. What are the typical  
9 qualifications for people who do intake  
10 investigation work?

11 A. We have a range of experience  
12 on the team. We have lawyers, nurses,  
13 experienced nurses. From time to time we have  
14 had police backgrounds in members who are  
15 investigators. They all have a background that  
16 involves assessing information, analyzing  
17 information and have very strong communication  
18 skills.

19 Q. Thank you. And then at  
20 paragraph 83, you indicate Intake Investigators  
21 do not have the power to compel evidence, and  
22 by that do you mean that at the intake stage  
23 there is not a legislative authority to obtain  
24 evidence from anyone else?

25 A. That's correct.

26 Q. Okay, and you then state  
27 that:

28 "The Intake Investigator role  
29 involves a triage function, and  
30 requires the Intake Investigator  
31 to conduct a risk assessment and  
32 determine the appropriate



1 regulatory response."  
2 Correct?  
3 A. That's correct.  
4 Q. And one of the possible  
5 regulatory responses would be whether or not to  
6 conduct a formal investigation of the report?  
7 A. That's correct.  
8 Q. And then at paragraph 84 you  
9 state that the Intake Investigator is assigned  
10 to the matter, makes inquiries into the report  
11 to gather further relevant information and  
12 assesses that information; correct?  
13 A. Yes.  
14 Q. And you state that:  
15 "Typically, an Intake  
16 Investigator begins by reviewing  
17 the report received by the  
18 College [...]"  
19 So in this case, it would be  
20 presumably the cover letter from Caressant and  
21 then that chart which we'll turn to later?  
22 A. That's correct.  
23 Q. And the member's history with  
24 the College, if any?  
25 A. Yes.  
26 Q. And then:  
27 "The Intake Investigator will  
28 then contact the individual who  
29 submitted the report to the  
30 College [...]"  
31 Correct?  
32 A. Yes.

1 Q. And then determine after that  
2 the review of the report, the prior history and  
3 contact with the reporter, if we can call it  
4 that, whether any further steps are necessary?

5 A. Yes.

6 Q. And you have indicated, as I  
7 noted at paragraph 83, that the Intake  
8 Investigator role involves the performance of a  
9 risk assessment?

10 A. That's correct.

11 Q. And this is an assessment of  
12 what kind of risk?

13 A. Assessing the risk of harm to  
14 clients.

15 Q. Patients, essentially?

16 A. Patients, clients, residents,  
17 yes.

18 Q. Now, I'm going to ask you to  
19 turn within your affidavit to Exhibit "S", and  
20 this is document 69065, and it is called  
21 "College of Nurses of Ontario, Risk Assessment  
22 Tool"?

23 A. Yes.

24 Q. And the date is May 2016, and  
25 so it was as of that date that the College used  
26 this Risk Assessment Tool?

27 A. That's correct.

28 Q. And is this a document that  
29 was or a tool that the College commissioned  
30 someone to produce for it?

31 A. That's correct, in  
32 collaboration with College staff.

1 Q. Okay. And what was the  
2 purpose of the Risk Assessment Tool?

3 A. The purpose was to identify,  
4 based on our standards, what potential risks  
5 exist in the practice of nursing that could  
6 create a consistent way to assess incoming  
7 matters to the College.

8 Q. Okay, and if we turn to page  
9 3 of this document and we scroll down to --  
10 that is fine there. You see there it says "The  
11 Tool is designed [...]"?

12 A. Yes.

13 Q. Okay, so:

14 "The Tool is designed to support  
15 the Intake Team who receive,  
16 review and make inquiries [...]"  
17 And then it says below that:  
18 "Consistency and reliability  
19 will be achieved when:"

20 And essentially, different  
21 people use the tool and they get to the same  
22 result?

23 A. That's correct.

24 Q. And if we look at the tool,  
25 is it correct that we could summarize it as a  
26 series of questions which the Intake  
27 Investigator should ask him or herself when  
28 assessing risk?

29 A. Correct.

30 Q. Okay, and if we look at  
31 examples of what those questions are, if you  
32 turn to page 9, for example, and we see an

1 example under "Step 3: Previous  
2 Report/Complaint", and then under "Descriptor"  
3 there is questions like:

4 "At least one previous report  
5 has been filed [...] and action  
6 was taken."

7 And the if you go over to the  
8 right-hand side, there is an assigned point  
9 value?

10 A. Yes.

11 Q. Okay. And then essentially  
12 was the process or is the process of this tool  
13 that you answer the questions in this question  
14 under Step 3 and determine which category the  
15 particular report that you are considering  
16 falls into?

17 A. The particular category of  
18 risk, yes.

19 Q. Okay. So in looking at this,  
20 if there had been one previous report about the  
21 same issue, it would have an assigned value of  
22 2 points?

23 A. Yes.

24 Q. Okay, and if there had been  
25 no prior reports filed about the member, it  
26 would have an assigned value of 1 point?

27 A. That's correct.

28 Q. Okay. And then just to get a  
29 sense of the other questions, and I am not  
30 going to go over all of them, but if you look  
31 at page 11, there is a question at the top of  
32 the page under "Experience levels" and it looks

1 like it is designed to give some latitude to a  
2 nurse who may be in a difficult work  
3 environment or may be a new graduate --

4 A. That's correct.

5 Q. -- compared to an experienced  
6 nurse?

7 A. Yes.

8 Q. Okay. And then under "Step  
9 6", there is "Violence", so that if the issue  
10 in the report constitutes a violent act, that  
11 would have a certain assigned value, and if it  
12 does not constitute a violent act, it would  
13 have another assigned value?

14 A. Correct.

15 Q. Okay. And then over to page  
16 12, there is categories to assess whether the  
17 issue caused or could have caused or the matter  
18 being reported caused or could have caused  
19 significant harm, whether it involved an  
20 intentional act or a reckless act?

21 A. Correct.

22 Q. Et cetera?

23 A. Yes.

24 Q. And then if you turn to page  
25 14 and you look down at Step 12, what is Step  
26 12 designed to consider or elicit and why?

27 A. This step is looking at the  
28 member's accountability and whether there is  
29 insight and accountability for the reported  
30 incident and steps have been taken to address  
31 any gaps in knowledge, or is there a denial or  
32 a hostility involved in the discussion of the

1 incident in the workplace.

2 Q. Okay. And from your  
3 affidavit, am I correct that between 2006 and  
4 March 2014, the Intake Investigator would use  
5 the Risk Assessment Tool by answering these  
6 questions on a computer spreadsheet?

7 A. That's correct.

8 Q. Okay, and so they would  
9 assign a -- they would answer each of these  
10 questions, and there would be an assigned point  
11 value generated?

12 A. That's correct.

13 Q. And then the Intake  
14 Investigator would print out that document?

15 A. Yes.

16 Q. Okay. And the printout,  
17 would it show what had been answered in each of  
18 these categories?

19 A. Yes, it would.

20 Q. And then with that printout,  
21 would there be a final score at the bottom?

22 A. Yes.

23 Q. And was it the intention to  
24 use that score to assist in assessing risk?

25 A. Originally, the hope had been  
26 that the tool would be sensitive enough to be  
27 able to use a score in a reliable way. That  
28 was not our experience.

29 And so over time, there was an  
30 assessment to look at the original goals of  
31 this work, and it didn't meet - and I just saw  
32 the language here that I can go back to

1 quickly - it didn't meet the common sense  
2 litmus test, the number didn't.

3 The actual assessment of risk  
4 and those categories did contribute to the  
5 consistent review and assessment of each file,  
6 so the inter-rater reliability was very high  
7 using the tool and the specific areas,  
8 categories of risk.

9 So that score, although it was  
10 calculated, did not -- I did not find that  
11 helpful in making my final decision, and over  
12 time, the investigators recommended that that  
13 piece of the tool was not as sophisticated as  
14 we had hoped it might be. And there was a  
15 decision to stop using the scoring but to  
16 continue to use the categories of risk.

17 Q. Okay. And so when the  
18 scoring was still being used, and then I'm  
19 going to ask you some questions following up on  
20 your answer, but when the scoring was still  
21 being used, was there a particular score, a  
22 particular number that would dictate a  
23 particular regulatory response?

24 A. No. It never reached that --  
25 we never reached that level of confidence.

26 Q. And --

27 A. I should say that the one  
28 area where the score tended to be reliable was  
29 in assessing cases of incapacity, so that was  
30 the one area where my recollection is that  
31 there was a consistent high score.

32 Q. Okay.

1 A. But I don't remember a  
2 specific number.

3 Q. And when you talk about  
4 reliability, if I understand you correctly,  
5 there was, using this tool, there was good  
6 inter -- I think you said inter-rater  
7 reliability?

8 A. Yes, so there was consistency  
9 between investigators who used the same tool.

10 Q. Okay, so there was  
11 consistency between investigators in terms of  
12 the score that this tool would generate?

13 A. Not the score necessarily.  
14 The categories and the assessment of level of  
15 risk using these categories.

16 Q. Okay. And then you said at a  
17 certain point, and I guess this is leading up  
18 to March 2014, the decision was made to stop  
19 using this tool in terms of inputting the  
20 numbers into the computer?

21 A. That's correct.

22 Q. And so what was the process  
23 that started at that time, March 2014?

24 A. The process changed to what  
25 we call a memo, and the memo summarized the  
26 assessment of the categories of risk.

27 Q. And was the expectation that  
28 the memo would summarize the same categories of  
29 risk that we see in the Risk Assessment Tool?

30 A. Yes.

31 Q. So when that change happened,  
32 am I correct there would no longer be a



1 printout for you to look at as Registrar, but  
2 you would instead receive a memo commenting on  
3 the risk factors?

4 A. That's correct.

5 Q. So at the time of the  
6 consideration of the Caressant Care report,  
7 this was a few months after that switch had  
8 taken place; correct?

9 A. Yes.

10 Q. Okay. And so the  
11 consideration of that report was done using the  
12 memo process as opposed to the printout  
13 process?

14 A. That's right.

15 Q. Now, if you turn back to your  
16 affidavit, page 36, please, and at page 36 you  
17 indicate that after the Intake Investigator  
18 goes through the process that you have  
19 described, they read the report, they interview  
20 the reporter or call the reporter and they do a  
21 risk assessment, previously on the  
22 computer-generated printout and then after  
23 March 2014 on the memo, that they would then  
24 present the results of their consideration to  
25 an intake review meeting?

26 A. That's correct.

27 Q. And I'll ask Ms. Yee more  
28 about the actual intake review meeting process.  
29 Did you tend to go to the intake review  
30 meetings?

31 A. No, I did not.

32 Q. And at the intake review

1 meetings, to the best of your understanding,  
2 would the assessment of the Intake Investigator  
3 be presented?

4 A. Yes, it would. I should say  
5 I didn't go on a regular basis. I may have  
6 gone once or twice to observe the process,  
7 because I do remember attending one, but I was  
8 not a regular participant in those meetings.

9 Q. And then if at the intake  
10 review meeting there is disagreement about the  
11 recommendation being made by the Intake  
12 Investigator, what was the process coming out  
13 of that?

14 A. So the process was that the  
15 memo that I received would reflect both the  
16 Intake Investigator's assessment and the  
17 recommendation coming out of the discussion at  
18 the intake review meeting.

19 And if at the intake review  
20 meeting they were not able to come to some  
21 recommendation, that would often then involve a  
22 discussion with the Director of Professional  
23 Conduct before a recommendation came to me.

24 Q. But it would be on some --  
25 that sometimes you would get a memo that would  
26 show that there had been some disagreement  
27 about the recommendation?

28 A. Yes.

29 Q. Okay. Now, after, if you  
30 turn now to the bottom of page 36, which is  
31 paragraph 91, and here you have indicated that:

32 "After the Intake Investigator's

1 investigation and recommendation  
2 are reviewed, the results of the  
3 Intake Investigator's  
4 investigation, the report  
5 itself, [and] the member's  
6 history", and then over the  
7 page, "and the recommendation of  
8 the appropriate regulatory  
9 response are submitted to the  
10 Registrar", which is you, "for  
11 [your] consideration and  
12 determination of the [...]   
13 regulatory outcome"?

14 A. Correct.

15 Q. And just the use of the word  
16 "investigation", I just want to make clear, at  
17 this time, during this assessment phase, has a  
18 formal investigation been commenced?

19 A. No, it has not.

20 Q. So is it more of an  
21 assessment or triage phase?

22 A. Yes, it is, or -- yes, an  
23 assessment or a triage phase.

24 Q. Which may or may not  
25 ultimately result in a formal investigation?

26 A. That's correct.

27 Q. And in terms of what you  
28 would receive and the process, would the Intake  
29 Investigator or anyone else come to your office  
30 and present to you about their findings and  
31 their assessment?

32 A. Very occasionally the

1 coordinator and the investigator, or at times  
2 where there were very serious concerns, the  
3 director and the investigator would attend, but  
4 that would be very rare.

5 Q. Okay, so in general, it would  
6 be a paper review that was provided?

7 A. Yes.

8 Q. Okay. And then the paper --  
9 you would receive a package of materials,  
10 essentially?

11 A. I would.

12 Q. And what was your practice in  
13 terms of what you would review in that package  
14 of materials?

15 A. So I would review the memo  
16 from the Intake Investigator, which includes a  
17 summary of the incidents that have come to the  
18 College's attention, a brief summary of the  
19 member's history with the College, registration  
20 date, where the member is currently working, if  
21 currently working, and then a summary of the  
22 concerns and an assessment of the risk factors  
23 that the concerns raise, as well as an  
24 identification of the relevant standards that  
25 relate to the incidents reported. And that  
26 memo also includes then a recommendation in  
27 regards to a regulatory action. So that is one  
28 piece of the file.

29 I also have in that file a copy  
30 of any interviews that the Intake Investigator  
31 has conducted, and I would review that. Those  
32 memos report discussions with the reporter.

1 I would also review the report  
2 itself, so the Report Form that the employer or  
3 facility operator has completed.

4 And where there is prior  
5 history, that information is also provided in  
6 the file, and I would review that.

7 And anything else, so very  
8 occasionally the member herself or himself will  
9 want to alert the College that they are aware  
10 that the College is receiving a report and will  
11 send in an email or a piece of correspondence,  
12 and I would review that.

13 So I would review the package  
14 that is presented to me.

15 Q. Okay. And in terms of the  
16 prior history, we know in this case that Ms.  
17 Wettlaufer had a prior file at the College  
18 resulting from the Geraldton incident?

19 A. That's correct.

20 Q. Okay, and so what would be in  
21 the file that you would have been provided with  
22 about that? Would it be the entire College  
23 file or a portion of it?

24 A. So I can't recall this  
25 specific review, and if available, and when I  
26 say "if available", sometimes we have to  
27 retrieve files from storage off-site, but most  
28 of the time the file would have been retrieved  
29 and I would have that attached to the file.

30 So my recollection -- you know,  
31 my assumption from reading through the file is  
32 that I did have the full file at the time, and

1 what I would check in there was what was the  
2 matter, the previous matter, and would have  
3 noted that there had been a finding of  
4 incapacity.

5 I would look at what contributed  
6 to the finding of incapacity, and what I would  
7 be looking for is, is there any connection  
8 between the concerns that arose at the time of  
9 the previous matter and the concerns that are  
10 presently being considered by the College. So  
11 I would be looking to see if there is any  
12 connection.

13 Q. And when you are doing this  
14 review, do you on occasion have questions or  
15 concerns as a result of what the Intake  
16 Investigator is putting to you or is  
17 recommending to you?

18 A. Occasionally, yes.

19 Q. And what would be the process  
20 if, for example, you had further questions  
21 arising from your review?

22 A. I would request a discussion  
23 with the Intake Coordinator because the Intake  
24 Coordinator has been part of the intake review  
25 process, and we would have a discussion so that  
26 I could understand what the discussion was at  
27 the intake meeting and --

28 Q. Could I just stop you there?

29 A. Yes.

30 Q. Sorry to interrupt. Is the  
31 Intake Coordinator the supervisor of the Intake  
32 Investigators?

1 A. In a sense, yes.

2 Q. Okay.

3 A. Yes, the Intake Coordinator  
4 provides oversight, support, expert advice,  
5 provides the orientation and mentoring of  
6 investigators and has an overview of all of the  
7 reports that are currently being assessed by  
8 the College and also has a good appreciation of  
9 how the College has addressed reports of a  
10 similar kind over time.

11 Q. Okay. So if you had any  
12 questions, you would consult with the Intake  
13 Coordinator?

14 A. I would, and if that  
15 individual was not able to assist, I would  
16 consult with the manager or the director.

17 Q. Okay. And were there  
18 occasions where you didn't necessarily have any  
19 questions; you just didn't agree with the  
20 recommendation that was being put forward?

21 A. Occasionally, yes.

22 Q. Okay. And then what would  
23 happen in that case?

24 A. A similar process. I would  
25 have a discussion to identify what my  
26 assessment was and what I was considering, make  
27 sure I wasn't missing something that the team  
28 had discussed or had observed in their  
29 assessment of the report, and then I would make  
30 my final decision.

31 Q. And ultimately, is it your  
32 final decision at the end of the day?

1 A. It is.

2 Q. And is it your decision in  
3 all cases of report, so every report that comes  
4 in to the College, you ultimately determine the  
5 regulatory response?

6 A. That's correct. That is in  
7 legislation that that is the Registrar's  
8 accountability.

9 Q. If you turn now in your  
10 document brief to tab 35, which is document  
11 36848, this is the cover letter which attached  
12 the Caressant Care report; correct?

13 A. That's correct.

14 Q. And it appears from the date  
15 stamp that it was received at the College on  
16 May 1st, 2014?

17 A. That's correct.

18 Q. And Caressant Care is  
19 reporting in this cover letter that, in the  
20 second sentence:

21 "[Ms. Wettlaufer] was terminated  
22 due to a medication error which  
23 resulted in putting a resident  
24 at risk."

25 Correct?

26 A. Yes.

27 Q. And if you go behind the blue  
28 sheet, you will see document 36841, and this is  
29 the Caressant Care Report Form that was  
30 attached to the cover letter?

31 A. That's correct.

32 Q. And received, of course, on



1 the same date, May 1st?

2 A. Yes.

3 Q. Okay. And is this a -- or it  
4 appears to be a College-generated document, so  
5 the College provides this document for  
6 employers to fill out?

7 A. That's correct.

8 Q. And in terms of the process,  
9 how would an employer obtain this document? Is  
10 it on a website?

11 A. Yes, it is.

12 Q. And then can they complete it  
13 and submit it to the College electronically?

14 A. No, they can complete it  
15 electronically, and then currently they are  
16 required to print it and either fax it or mail  
17 it to the College.

18 Our technology system is not yet  
19 at the stage where the document can be  
20 submitted online. That is in process.

21 Q. Okay, so they can access it  
22 and type into it online, but then ultimately  
23 they need to print it and mail it or fax it to  
24 the College?

25 A. That's correct.

26 THE COMMISSIONER: And just to  
27 put that in the context in time,  
28 was that the same situation that  
29 was available in 2014 and now?

30 BY MS. JONES:

31 Q. Ms. Coghlan, that was the  
32 same in 2014; correct?

1 A. That's correct.

2 Q. And it says -- it appears to  
3 be a five-page document; correct? If you look  
4 at the --

5 A. That's correct.

6 Q. Okay, and so what would an  
7 employer do if they wanted to provide more  
8 information?

9 A. They would duplicate pages  
10 that are part of the tool or they would attach  
11 additional pages that they generated themselves  
12 in, you know, a Word document or --

13 MR. GOLDEN: Commissioner, I  
14 rise.

15 I am not sure how this witness,  
16 given what she has said her  
17 knowledge of this process is,  
18 can say what employers would do.  
19 I mean, she hasn't investigated  
20 that. She hasn't talked to the  
21 employers. This is pure  
22 speculation on her part about  
23 what they would do and what they  
24 might attach.

25 MS. JONES: Commissioner, Ms.  
26 Coghlan has indicated that she  
27 would review as part of her  
28 process the reports that came in  
29 to the College, so she would, of  
30 course, through that process  
31 have experience in determining  
32 what the process was when an

1 employer had more information or  
2 what it could be.

3 THE COMMISSIONER: I think the  
4 question and answer are  
5 speculative as it is. If you  
6 want to rephrase your question  
7 as to whether she had any  
8 experience of whether there were  
9 at that time in 2014 either  
10 instructions about this issue on  
11 the website or in the document  
12 or in some other fashion or  
13 whether or not she actually  
14 physically had seen employers  
15 who had dealt with this in some  
16 other way, you can do it that  
17 way.

18 BY MS. JONES:

19 Q. Sure. Ms. Coghlan, in 2014  
20 were there instructions provided by the College  
21 about what to do if an employer needed more  
22 space on the form?

23 A. I can't recall if there were  
24 specific instructions about whether an employer  
25 needed more space. However, I do recall it was  
26 not unusual to receive reports from employers  
27 that included more than five pages and that  
28 included pages that were not the College's  
29 form.

30 Q. Thank you. Ms. Coghlan, do  
31 you today have any recollection at all of  
32 considering the Caressant Care report?

1 A. I do not.

2 Q. And am I correct that it is  
3 most likely the case that your first  
4 involvement with this report would have been  
5 after the assessment process by the Intake  
6 Investigator, after the intake review meeting  
7 and when you received the package of materials?

8 A. That's correct.

9 Q. And based on your evidence  
10 about your standard practice, do you believe  
11 that you would have reviewed the memo, which  
12 we'll turn to in a moment, prepared by Ms. Yee  
13 providing her summary and assessment?

14 A. I do.

15 Q. And do you believe that you  
16 would have reviewed the memo of the interview  
17 summary with Ms. Crombez?

18 A. Yes.

19 Q. And do you believe you would  
20 have reviewed the Caressant Care report itself?

21 A. Yes.

22 Q. And then in terms of the  
23 fitness to practise file, you described your  
24 general practice. Given this file, what we  
25 know about this file, do you have any belief  
26 about what in particular you would have  
27 reviewed within the fitness to practise file?

28 A. Well, I certainly would have  
29 reviewed the summary information that the  
30 investigator provided, and I can't  
31 independently recall, but I very likely would  
32 have looked at the decision of the Fitness to

1 Practise Committee.

2 Q. Okay, and the summary that  
3 the investigator provided, that would be the  
4 summary within the memo?

5 A. That's correct.

6 Q. Okay. So if we turn to the  
7 memo itself, would you have, in reviewing this  
8 memo -- or this report, I should say. We are  
9 looking at the Report Form from Caressant, I  
10 apologize. You should still be behind tab 35,  
11 behind the blue sheet. Would you have reviewed  
12 each of the entries in turn?

13 A. I believe so, yes.

14 Q. So I'm going to ask you to  
15 turn on page 4, please, to the first entry  
16 which is dated March 20th, 2014?

17 A. Yes.

18 Q. And we see under "Employer  
19 Action" that it says "Termination", so would  
20 you have understood this to be the termination  
21 event?

22 A. Yes.

23 Q. And in terms of the incident,  
24 is it fair to summarize the incident that you  
25 would have reviewed as Ms. Wettlaufer  
26 administering insulin to a resident that  
27 belonged to another resident and that it was a  
28 different kind of insulin that she  
29 administered?

30 MR. GOLDEN: Commissioner, I  
31 need to understand where this  
32 line of questioning is going.

1 We have already established  
2 through the evidence that this  
3 witness has no recollection at  
4 all of ever seeing this form.  
5 The only basis for her evidence  
6 that she might have seen the  
7 form is that that was the usual  
8 process, but she doesn't  
9 remember it.  
10 We have a 54-page affidavit that  
11 was submitted. Nowhere in that  
12 affidavit is it suggested that  
13 she actually is going to review  
14 the form, is going to have some  
15 views on it or opinions about  
16 it.  
17 Everything in relation to this  
18 form we anticipate from the  
19 witness statements is going to  
20 come from Karen Yee.  
21 We also had advanced notice from  
22 the College going back to April  
23 about their intention to call  
24 this witness to give evidence.  
25 Nowhere in those notices does it  
26 say that she is going to comment  
27 on the contents of this and have  
28 some view.  
29 So other than the fact that the  
30 witness says there was a process  
31 and that likely she would have  
32 seen the form, there is no basis

1 for her now commenting on the  
2 specifics that has been  
3 established, as far as I can  
4 see. That is my concern.  
5 THE COMMISSIONER: Just before  
6 you -- and I will give you time.  
7 Just before you sit down, Mr.  
8 Golden, speaking for myself,  
9 obviously it is a critical  
10 aspect of this Inquiry as to why  
11 she did what she did because,  
12 ultimately, as I understand the  
13 legislative scheme, it was up to  
14 her as Registrar to determine,  
15 for example, whether or not this  
16 was fully investigated and they  
17 were content with the telephone  
18 conversation with one person who  
19 didn't even have the report in  
20 front of her.  
21 So I understand what you are  
22 saying about the affidavit  
23 evidence. Obviously we have all  
24 reviewed it carefully on this  
25 point.  
26 I am not sure that I understand  
27 your objection to questions  
28 being put to this witness about  
29 this matter so that we have the  
30 fullest understanding of, not  
31 speculatively, but what she did  
32 and why.

1 So help me understand why this  
2 line of questioning would not be  
3 proper by --  
4 MR. GOLDEN: The concern is  
5 exactly for the reason,  
6 Commissioner, you have just  
7 alluded to. It is entirely  
8 speculative. The witness has  
9 said she has no recollection of  
10 receiving the form. We don't  
11 even know, because we haven't  
12 heard yet from Karen Yee, nor is  
13 there any evidence in the  
14 thousands of pages that the  
15 College produced that there was  
16 a file put together and what the  
17 contents of that file were for  
18 this particular witness.  
19 So she is now looking at it and  
20 today saying, I might have read  
21 this; I might have thought that.  
22 There is no basis for this  
23 evidence other than the fact  
24 that we have heard her say she  
25 reads the recommendation, she  
26 reads to see whether the  
27 committee below had any concern  
28 about it, and that she would  
29 also typically read the form.  
30 But that is the extent of it.  
31 THE COMMISSIONER: Let me hear  
32 first from the College, and then



1 I will hear from you, Ms. Jones.  
2 MS. ROTHSTEIN: Well, thanks  
3 very much, Commissioner. I am  
4 sort of new to these debates, so  
5 perhaps I am not up to date on  
6 your thinking and the thinking  
7 of others, but I approach the  
8 issue in this way.  
9 First of all, I think there has  
10 been adequate notice given to  
11 our friends that this was always  
12 part of the College's file, and  
13 the entire file has been  
14 produced. It has been available  
15 for everyone to review from the  
16 outset. And it is in our notice  
17 of documents that this was going  
18 to be the subject of  
19 questioning.  
20 It actually never occurred to me  
21 that there would be any  
22 objection taken to this part of  
23 the evidence.  
24 Secondly, what you --  
25 THE COMMISSIONER: Sorry, is  
26 there anything specific in the  
27 affidavit --  
28 MS. ROTHSTEIN: Not anything  
29 specific in the affidavit  
30 because we knew it would be the  
31 subject of evidence. I don't  
32 think that any of us understood

1                   that the affidavits were to be  
2                   an exhaustive review of the  
3                   evidence the witnesses would  
4                   give. At least I didn't.  
5                   THE COMMISSIONER: It is not  
6                   meant to be exhaustive.  
7                   MS. ROTHSTEIN: Yes, and the  
8                   summaries were given as well,  
9                   which clearly deal with this.  
10                  THE COMMISSIONER: But the  
11                  summary statements I don't have;  
12                  the summary statements are not  
13                  available to the public; and the  
14                  summary statements are not  
15                  available for the purposes of  
16                  cross-examination according to  
17                  our rules.  
18                  MS. ROTHSTEIN: Oh, I understand  
19                  that. I am suggesting that my  
20                  friend -- from the fairness  
21                  perspective, I think my friend  
22                  will have notice about what this  
23                  witness was intending to say.  
24                  So let me deal with the other  
25                  point that Counsel makes.  
26                  And I think it is important,  
27                  Commissioner, to understand that  
28                  this witness clearly did review  
29                  this material. There is no  
30                  doubt about it. She just  
31                  doesn't have an independent  
32                  recollection of her precise

1 thinking around it any more to  
2 offer.  
3 THE COMMISSIONER: I think she  
4 said she has no recollection of  
5 the report. That is --  
6 MS. ROTHSTEIN: No, no, I think  
7 that is an unfair  
8 characterization of what she  
9 said.  
10 THE COMMISSIONER: All right.  
11 MS. ROTHSTEIN: She clearly  
12 signed it. She clearly signed  
13 off on it. She knows she  
14 reviews all these documents.  
15 That is her standard practice.  
16 That is a common feature of the  
17 way anyone in this day and age  
18 will review multi-documents over  
19 time.  
20 THE COMMISSIONER: Okay.  
21 MS. ROTHSTEIN: So I don't think  
22 it is fair to say that there is  
23 any doubt that she reviewed it.  
24 The only issue is what her  
25 thought process was at the time.  
26 THE COMMISSIONER: Right, but  
27 can I have a read-back on this  
28 issue from the transcriptionist,  
29 please? I have the words: I  
30 have no independent recollection  
31 of this report.  
32 MS. ROTHSTEIN: Independent

1 recollection, correct.  
2 THE COMMISSIONER: Right.  
3 MS. ROTHSTEIN: Right, but that  
4 isn't the same thing, in my  
5 respectful view, Commissioner,  
6 as saying that she didn't  
7 actually see it. She is telling  
8 you --  
9 THE COMMISSIONER: No, no, I  
10 don't think there is any doubt  
11 that she saw the report.  
12 MS. ROTHSTEIN: That was my  
13 point.  
14 THE COMMISSIONER: She made a  
15 decision.  
16 MS. ROTHSTEIN: Yes.  
17 THE COMMISSIONER: Okay.  
18 MS. ROTHSTEIN: Okay, that was  
19 the point I was trying to make,  
20 Commissioner.  
21 So I think you are in the  
22 situation where this isn't a  
23 trial. This is a Public  
24 Inquiry, and you need to get to  
25 the bottom not only of what she  
26 saw and what she remembers. You  
27 actually need to get to the  
28 bottom of what the College does  
29 and doesn't do and what it views  
30 as important and not important  
31 and how, going forward, you are  
32 going to make the appropriate

1 recommendations about what  
2 should be contained in  
3 termination reports and what  
4 shouldn't be.  
5 And with the greatest of  
6 respect, it seems to me that  
7 public inquiries take a bigger  
8 view, therefore, of the extent  
9 to which questions can be put to  
10 witnesses that have some  
11 hypothetical or perhaps, to use  
12 my friend's language,  
13 speculative aspect with a view  
14 to getting to the systemic  
15 issues in the case.  
16 And this case isn't simply about  
17 whether or not Ms. Coghlan can  
18 remember what she said and what  
19 she didn't. This case is, more  
20 importantly, about from a  
21 systemic perspective,  
22 Commissioner, about how the  
23 College does this process and  
24 how, frankly, Ms. Coghlan, who  
25 is one of the foremost nurse  
26 regulators in our country,  
27 approaches issues like this.  
28 THE COMMISSIONER: Well, we have  
29 had that. I don't think there  
30 is any question --  
31 MS. ROTHSTEIN: But I don't --  
32 THE COMMISSIONER: But I need to

1 hear from you specifically about  
2 the concern that Mr. Golden  
3 raises.  
4 Mr. Golden says nothing specific  
5 in the affidavit so that they  
6 could get -- that he could get  
7 prepared for it, effectively.  
8 We have heard about the process.  
9 His concern is that when we  
10 start to talk about and hear  
11 evidence on the report and there  
12 is no independent recollection  
13 of it, his concern, as I  
14 understand it, is about the  
15 nature of the way in which the  
16 questions were being put, which  
17 was to suggest that she had --  
18 that she could tell us today  
19 this was my assessment of it.  
20 MS. ROTHSTEIN: Yes.  
21 THE COMMISSIONER: So I take  
22 fully - and I am happy to go  
23 on - but I take fully the need  
24 for the questions to be put to  
25 this witness about her handling  
26 of the report.  
27 MS. ROTHSTEIN: Right.  
28 THE COMMISSIONER: She had  
29 ultimate responsibility for it,  
30 and it was as a result of her  
31 decisions that the process  
32 unfolded with Elizabeth

1                   Wettlaufer as it did in relation  
2                   to this.  
3                   I think, as I understand it, it  
4                   is this question of trying to  
5                   suggest that we can now know  
6                   what was in her mind or how she  
7                   assessed it if she has no  
8                   independent recollection.  
9                   MS. ROTHSTEIN: Okay, well,  
10                  Commissioner --  
11                  THE COMMISSIONER: And just a  
12                  second. Am I right in the way I  
13                  understand your question?  
14                  MR. GOLDEN: Yes.  
15                  THE COMMISSIONER: Or your  
16                  objection.  
17                  MR. GOLDEN: Because what we are  
18                  doing is we have no notes that  
19                  were taken contemporaneously to  
20                  assist the witness in refreshing  
21                  her review and we --  
22                  THE COMMISSIONER: Just a  
23                  second, because we need to go a  
24                  little bit in turn here.  
25                  Am I right about the basic  
26                  nature of your objection to it?  
27                  MR. GOLDEN: Yes.  
28                  THE COMMISSIONER: Is to try to  
29                  figure out now what her thinking  
30                  process was on it when she  
31                  doesn't have --  
32                  MR. GOLDEN: Correct.

1 THE COMMISSIONER: All right.  
2 MR. GOLDEN: And then to hear  
3 that for the first time on July  
4 the 25th, you know, in this  
5 context.  
6 THE COMMISSIONER: Okay, all  
7 right. So it seems to me that  
8 there are a few things.  
9 Firstly, if I have to rule on  
10 this, I will rule.  
11 But the question, it is  
12 legitimate and it is important  
13 for this Public Inquiry that we  
14 allow Commission Counsel to put  
15 the nature of the questions that  
16 she is to this witness.  
17 We also have to be careful to  
18 guard against - my words, not  
19 anybody else's - but looking  
20 back and speculating about what  
21 might have been in her mind.  
22 I mean, the witness can talk  
23 about her process, which she  
24 has, and the witness can say  
25 what, on her reading of it, she  
26 thinks the significance of the  
27 documents were. But we don't  
28 lead on questions where we don't  
29 have an evidentiary basis, and  
30 the evidentiary basis we don't  
31 have is as to anything apart  
32 from what was in the report.



1 With this in mind, what I would  
2 propose is this. I think that  
3 counsel should get together and  
4 talk about the nature of the  
5 questions so that we don't  
6 engage in lots of question,  
7 objection and so on, and see if  
8 we can come up with a bit of a  
9 framework about the nature of  
10 the questions; and if you can't,  
11 where you agree, where you  
12 disagree, and then I will rule  
13 on it, because I have no doubt  
14 that with the level of  
15 experience and expertise in this  
16 room, that you guys can come up  
17 with a series of at least areas  
18 of questions and approach to  
19 questioning that is acceptable.  
20 So I didn't mean to cut you off.  
21 MS. ROTHSTEIN: Not a problem,  
22 Commissioner.  
23 THE COMMISSIONER: All right.  
24 MS. ROTHSTEIN: If I can just  
25 suggest that, yeah, I think that  
26 makes great sense. It may just  
27 be that we need to be careful  
28 about the way we frame  
29 questions, if that is your  
30 concern, and that is not  
31 problematic and well understood.  
32 I mean, from my perspective, in

1 terms of the kinds of questions  
2 I would be asking of this  
3 witness, it would be based on  
4 your experience, how would this  
5 kind of information likely have  
6 been treated by you, that sort  
7 of question, which isn't  
8 suggesting that she has an  
9 actual independent recollection  
10 that she is now proffering to  
11 the Commissioner.

12 THE COMMISSIONER: Well, I fully  
13 expect that the College is going  
14 to stand after Ms. Jones is  
15 completed and ask questions, and  
16 so it may be that if we put this  
17 together, the concerns and the  
18 two sets of questions, then --  
19 you know, and it doesn't matter  
20 who puts it.

21 But have I -- is there anything  
22 else in terms of a substantive  
23 point that I need to hear from  
24 you on before I sort of I think  
25 recess and allow some time for  
26 discussion on this?

27 Just let me deal with the  
28 primary things and then -- okay,  
29 so nothing else.

30 Ms. Jones, did you have any  
31 point to raise about this that  
32 we have not already heard from

1                   either Mr. Golden or Ms.  
2                   Rothstein?  
3                   MS. JONES: Yes, I did,  
4                   Commissioner, and it is just  
5                   this, that the affidavit was  
6                   clearly intended to disclose the  
7                   policy and structural issues  
8                   with the College, that was  
9                   disclosed to all counsel.  
10                  And there was also an extensive  
11                  witness summary that was  
12                  produced which is not for use in  
13                  the Inquiry but is for use in  
14                  disclosure about the types of  
15                  evidence that the witness would  
16                  be asked, and all the  
17                  participants were aware of that  
18                  for some time, that the  
19                  affidavit evidence was intended  
20                  to be the big overarching  
21                  structural evidence and that the  
22                  factual evidence that we would  
23                  then receive from the witnesses  
24                  would be based on the topics in  
25                  the witness summary, and that is  
26                  consistent with the Inquiry's  
27                  rules.  
28                  THE COMMISSIONER: Okay, where  
29                  in the rules do you see that  
30                  statement or in the  
31                  correspondence? I would like to  
32                  see that. I have not seen that

1 statement of --  
2 MS. JONES: Which statement in  
3 particular?  
4 THE COMMISSIONER: You have  
5 described a difference in the  
6 witness summary statements and  
7 the affidavit materials.  
8 MS. JONES: No, what the rules  
9 provide, Commissioner, is that  
10 the areas of examination, the  
11 topics for examination will be  
12 disclosed in a witness summary  
13 or in a statement of anticipated  
14 evidence which we did in the  
15 form of a witness summary.  
16 So that the topics of  
17 examination --  
18 THE COMMISSIONER: Okay, I wrote  
19 the rules, so just help me,  
20 because I think that there is a  
21 difference of view as to what  
22 the point of that is.  
23 Where is my rules? All right.  
24 MS. JONES: So Rule 43,  
25 Commissioner.  
26 THE COMMISSIONER: Yes, can you  
27 pull that up? Oh, actually --  
28 yes, you are going to have to  
29 pull it up on the screen.  
30 MS. JONES: I'm not sure if we  
31 have it electronically.  
32 THE COMMISSIONER: Anyway, okay,

1 read me out the rules.  
2 MS. JONES: Rule 43 provides  
3 that:  
4 "Lead Commission Counsel shall  
5 give Participants reasonable  
6 notice of the witnesses the  
7 Commission intends to call at  
8 the Public Hearings, an outline  
9 of the anticipated areas of  
10 examination for each such  
11 witness, and, where practicable,  
12 a statement of the anticipated  
13 evidence of the witness."  
14 THE COMMISSIONER: Okay, and  
15 what was the outline of  
16 anticipated evidence to be  
17 called through this witness?  
18 MS. JONES: That was provided by  
19 way -- the way we did it,  
20 Commissioner, was by way of  
21 interview summaries and  
22 disclosing to the participants  
23 that the areas of examination  
24 would be consistent with the  
25 witness summaries.  
26 THE COMMISSIONER: Okay, I  
27 haven't seen that document.  
28 MS. JONES: No, that was -- it  
29 wasn't intended to be entered  
30 into evidence. It was intended  
31 to, in essence, provide  
32 disclosure to the participants

1 about the areas of examination  
2 that would be explored.  
3 THE COMMISSIONER: Well, I can  
4 just say that, speaking for  
5 myself, that I see where some of  
6 the misunderstanding comes,  
7 because my understanding was  
8 that while interview summaries  
9 would be provided, that the  
10 affidavits were intended to be  
11 the primary basis on which  
12 evidence would be led here,  
13 because for example, I have not  
14 been given copies of the  
15 interview statements or the  
16 summary statements.  
17 So I can see where the gap in  
18 communication arose there.  
19 But in any event, what was your  
20 primary point, that you thought  
21 that the affidavits would  
22 address only policy and  
23 structural issues and that there  
24 would be other more pointed  
25 questions that would not be  
26 covered in the affidavit  
27 evidence but arising from the  
28 summary statements?  
29 MS. JONES: Commissioner, the  
30 rules don't contemplate or  
31 require affidavits. Not all of  
32 the witnesses have affidavits.

1 So what the rules contemplate is  
2 that there will be disclosure of  
3 the anticipated areas of  
4 evidence.

5 THE COMMISSIONER: Exactly.

6 MS. JONES: Which there has  
7 been.

8 THE COMMISSIONER: Okay, but I  
9 think that that is different.  
10 When the rules were written, I  
11 wrote it saying that there would  
12 be an outline of the anticipated  
13 evidence. And instead what  
14 happened, I understand, was that  
15 summary statements or interview  
16 statements were given.

17 That doesn't necessarily mean  
18 that it is an outline of the  
19 anticipated evidence.

20 MS. JONES: That was clarified,  
21 though, in advance, which was  
22 that the facts -- the  
23 questioning on the factual basis  
24 would be based on the witness  
25 summaries, so the topics in the  
26 witness summaries. So that  
27 effectively acted exactly in the  
28 same way, and that was disclosed  
29 to the participants in advance.

30 THE COMMISSIONER: Where is the  
31 document that shows that?

32 Ms. Jones, the bottom line is

1 that it is important, that the  
2 line of questioning that you are  
3 raising, in my view, is  
4 important. It is important that  
5 we hear from this person. She  
6 was the Registrar. She was the  
7 person who ultimately made the  
8 decision that the report from  
9 Caressant Care would not be  
10 investigated.  
11 So we are all agreed on that.  
12 The question is the way in which  
13 the questions are framed.  
14 So it seems to me that there are  
15 two different issues.  
16 One, is the line of questioning  
17 acceptable? And in my view, it  
18 is, and I have ruled on that.  
19 But then comes where we have no  
20 independent recollection of the  
21 decision and the process and so  
22 on - and that is no criticism of  
23 the Registrar - how is it  
24 acceptable to explore her  
25 understanding?  
26 And as I said, I have no doubt  
27 that if the affected counsel  
28 here and participants here put  
29 their heads together, you can do  
30 two things.  
31 You can come up with the areas  
32 that are agreed on, the areas



1                   that are not agreed on, and the  
2                   way in which those questions can  
3                   be approached that are  
4                   acceptable to everybody.  
5                   And as soon as we have got that,  
6                   if there is any areas of  
7                   disagreement, (a) they'll be  
8                   narrow; and (b) I can rule on  
9                   them.  
10                  And so we should be able to  
11                  advance this line of questioning  
12                  in an orderly fashion, whether  
13                  it is through you or through  
14                  Counsel for the College.  
15                  All I was really asking you is  
16                  whether in that framework there  
17                  were additional considerations  
18                  you wanted me to take into  
19                  account.  
20                  And what I hear from you is you  
21                  feel that, in a way, it was an  
22                  unfair criticism to suggest that  
23                  this line of questioning  
24                  wouldn't come because clearly  
25                  everybody should have known that  
26                  from the interview statements  
27                  and so on, and I hear you on  
28                  that.  
29                  MS. JONES: Okay, and I am  
30                  content to take a break and  
31                  consult with the participants  
32                  about the structure of questions

1 and to identify any particular  
2 issues about how those questions  
3 are going to be asked.  
4 But I do think it is important  
5 evidence. We know that the  
6 witness did review these  
7 documents and make that  
8 determination, and in the  
9 absence of an independent  
10 recollection, the only thing the  
11 witness can do is advise as to  
12 what considerations she would  
13 have had in reviewing a report  
14 of that nature.

15 THE COMMISSIONER: Thank you for  
16 that.

17 Yes, and I am now going to hear  
18 from everybody else to inform  
19 this process.

20 MR. VAN KRALINGEN: Actually, I  
21 have nothing to add at this  
22 point. Thank you.

23 THE COMMISSIONER: All right,  
24 thank you.

25 Ms. Hughes?

26 MS. HUGHES: Yes, I just wanted  
27 to add one thing, that we are  
28 some 20 days into this hearing.  
29 In the Facilities portion, Ms.  
30 Hewitt as Inquiry Counsel put to  
31 a number of witnesses -  
32 Caressant Care, for instance,

1 the Director of Nursing, the  
2 Administrator - documents that  
3 you may recall they said, Oh, I  
4 have no independent recollection  
5 of them. And it was a number of  
6 them, memos, interviews, et  
7 cetera. Some they were authors  
8 of; some they were not.  
9 And those documents, by the way,  
10 were not all in the affidavit.  
11 I just add that point too.  
12 And nobody had an objection at  
13 that point that the witness  
14 could speak to and answer  
15 questions about a document that  
16 they said I actually have no  
17 recollection of.  
18 And so I am puzzled why now we  
19 are getting bogged down in this  
20 phase of it, and I am concerned  
21 that we are going to have  
22 different considerations with  
23 respect to this phase than we  
24 had in the Facilities Phase  
25 where we had no problems with  
26 the witnesses being asked  
27 questions where they  
28 specifically said that we have  
29 no independent recollection,  
30 firstly; and secondly, where Ms.  
31 Hewitt didn't put them in the  
32 affidavit but entered them

1 afterwards and said, Well, you  
2 know, they were in the database  
3 or they were in the Overview  
4 documents or you had notice  
5 through the notes.

6 So I don't see any difference  
7 from what Ms. Jones is doing  
8 from what Ms. Hewitt was doing,  
9 so I just raise that to say we  
10 need to have consistency.

11 THE COMMISSIONER: Thank you. I  
12 think the consistency comes from  
13 my ruling that this line of  
14 questioning is acceptable.

15 What I am trying to do is  
16 streamline the process so that  
17 we don't have continual  
18 objections, depending on the  
19 nature of the question and the  
20 way they are phrased.

21 So I think now we have a  
22 framework within which counsel  
23 can have that discussion  
24 together.

25 But I totally take your point,  
26 Ms. Hughes, that where there are  
27 important documents, even if the  
28 witness does not have an  
29 independent recollection, that  
30 does not forestall or preclude  
31 questioning on it, so thank you  
32 for that.

1 Is there any other submission?  
2 Okay, in my view, the parties  
3 that need to have this  
4 discussion are largely Caressant  
5 and the College and Commission  
6 Counsel.  
7 I don't mean to exclude other  
8 people, but they are sort of  
9 hard questions and need to bear  
10 down.  
11 If I suggest that those parties  
12 now take 20 minutes to talk and  
13 identify the nature of the  
14 questions, the area and what  
15 ways in which they could be  
16 presented that would be  
17 acceptable to all, does that  
18 sound like a reasonable way to  
19 proceed?  
20 MS. JONES: Thank you,  
21 Commissioner.  
22 THE COMMISSIONER: Thank you.  
23 Oh, sorry, yes, are you trying  
24 to speak?  
25 MS. FRASER: I am, Madam  
26 Commissioner, only to say, given  
27 the past experience with  
28 discussions of this nature, even  
29 if we are to sit in on where it  
30 is going, it might speed things  
31 up later to know what the  
32 agreement is as it unfolds, and

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so --

THE COMMISSIONER: Everybody is welcome to sit in. I just wanted to try to focus the discussion amongst them. I would expect that the parties would come back and say effectively, within the confines of my ruling, which is this area of questioning is acceptable, and understanding there is no independent recollection, these are the type of questions that we are going to put, and so on, so that there is a shared understanding of the nature and phrasing of the questions.

MS. FRASER: Thank you, Commissioner.

THE COMMISSIONER: Thank you. So I think maybe 15 minutes is a bit ambitious, because sometimes it is more helpful to take a little bit of extra time and actually talk your way through it.

Shall we say for 11 o'clock? Everybody can take their break. We can take the morning recess at this time.

And if that is not enough time, you could see the CSO and she

1 will let me know, but otherwise,  
2 I feel confident that we can  
3 resume at 11 o'clock with that.

4 MS. JONES: Thank you.

5 -- RECESSED AT 10:31 A.M.

6 -- RESUMED AT 11:17 A.M.

7 THE COMMISSIONER: So have you  
8 been able to come to enough of  
9 an agreement that you are able  
10 to proceed with your  
11 questioning, Ms. Jones?

12 MS. JONES: Yes, Commissioner,  
13 the participants had a very  
14 fruitful discussion over the  
15 break and have agreed that I  
16 should proceed with the line of  
17 questioning as planned, and that  
18 Ms. Coghlan, having testified  
19 that she believes based on her  
20 practice that she would have  
21 reviewed the report, that she  
22 can and should be asked to  
23 comment on the report and, in  
24 particular, what her  
25 considerations would have been  
26 in reviewing the report based on  
27 her practice and experience.

28 THE COMMISSIONER: Thank you. I  
29 am glad to hear that.

30 Go ahead.

31 BY MS. JONES:

32 Q. So out of an abundance of

1 caution, though, Ms. Coghlan, I am not going to  
2 lead you as much through this report.

3 So let's resume with where we  
4 were before at document 36841, and that should  
5 be in your brief, Ms. Coghlan, at tab 35.

6 A. Yes, thank you.

7 Q. Okay. And when we left off  
8 at the break, we were at the entry on March 20,  
9 2014, and if you can assist us with -- we  
10 appreciate that you do not recall reviewing  
11 this report, but reviewing it now today, what  
12 consideration -- what you would have taken from  
13 this information and what considerations you  
14 believe you would have had based on your  
15 experience?

16 A. All right. And you want me  
17 to speak to this specific incident?

18 Q. Yes, we are going to go  
19 through each in turn.

20 A. So I read this as a  
21 medication error where insulin was delivered to  
22 a patient that belonged to another patient, so  
23 in other words, the insulin intended for this  
24 patient was not delivered and instead the  
25 insulin intended for another patient was  
26 substituted.

27 Q. Okay, and --

28 A. And that --

29 Q. Sorry, continue.

30 A. And that there is a  
31 difference in the report between what the  
32 colleague, the day nurse reported. She



1 reported that she had told the member that the  
2 insulin was not available and had been ordered,  
3 and the member, Ms. Wettlaufer, saying that she  
4 did not remember hearing this.

5 So those are the key pieces that  
6 I would identify here.

7 And do you want to know what my  
8 assessment is of this particular incident?

9 Q. Yes, and first to have you  
10 confirm, based on this information, is it fair  
11 to say that what is being reported involved  
12 both what appears to be a medication error in  
13 the traditional sense but also a deliberate  
14 breaking of a medication rule in terms of the  
15 substitution of one resident's insulin with  
16 another?

17 A. I don't have enough  
18 information to determine that it was  
19 deliberate. I think we have information that  
20 the wrong insulin was chosen to deliver to a  
21 resident, and whether that was -- I view this,  
22 again, from the information that is here, I  
23 would assess it as a mistake, which is a  
24 medication error and is a breach of the  
25 standard.

26 Q. And based on your experience  
27 reviewing these reports, what would your  
28 considerations have been in terms of assessing  
29 risk looking at this incident?

30 A. Well, first of all, in this  
31 incident, I can respond to that, but I would  
32 look at the full report in determining the risk

1 posed.

2 This incident on its own I would  
3 assess as on a scale that we use which is low,  
4 moderate or high risk, and I would characterize  
5 it as low risk.

6 Q. And if you could move now,  
7 Ms. Coghlan, to the next incident, which is at  
8 January 28th, 2014. And can you describe what  
9 you believe you would have understood from this  
10 entry and then explain, based on your  
11 experience reviewing these reports, what your  
12 considerations would have been?

13 A. So in reviewing this  
14 incident, I see poor communication with a  
15 client and the nurse exercising her own --  
16 using her own judgment to decide to give a  
17 medication outside of the allowable time frame.

18 I see that the employer has had  
19 communication with the member and has  
20 re-instructed the member about the approach to  
21 residents that is part of the standard policy  
22 of the facility. And I see that the resident  
23 was upset.

24 Q. And what do you believe,  
25 based on your experience, your assessment of  
26 this situation would have been?

27 A. So I would consider the  
28 therapeutic nurse/client relationship standard  
29 when looking at this incident and also observe  
30 that the employer has taken appropriate action.

31 Q. Over the page, please, Ms.  
32 Coghlan, now to page 6, and can you undertake

1 the same process with this entry, please?

2 A. So here I see the employer  
3 identifying an incident where the member did  
4 not follow proper policy and procedure, which  
5 resulted in an incorrect treatment of a  
6 hypoglycaemic episode, and that the charting  
7 was not sufficient or complete in this  
8 circumstance. I see that there -- that the  
9 resident was stable.

10 I also observe that the member  
11 reports that it was a busy night and that the  
12 employer has provided counselling. And in  
13 looking at this incident on its own, I would  
14 suggest that that was the appropriate action  
15 for the employer to take to re-direct the  
16 member.

17 Q. Okay. And what, if any,  
18 standards, for example, would be implicated in  
19 this incident?

20 A. Documentation standard, and  
21 then there is a general professional -- under  
22 those Professional Standards, on  
23 accountability, nurses are expected to follow  
24 workplace policies and procedures, so  
25 Professional Standards as well.

26 Q. And in terms of the  
27 assessment of risk, can you assist us with what  
28 your considerations would have been about the  
29 assessment of risk from this incident?

30 A. I would consider this low  
31 risk. It is certainly not no risk, but it is  
32 low risk, and that the appropriate intervention

1 is for it to be dealt with in the workplace,  
2 and that has occurred.

3 Q. Now, Ms. Coghlan, if you  
4 could turn to page 7 and the incident on  
5 December 19th, 2013, and walk us through what  
6 you would have appreciated from this incident?

7 A. So in this incident, the  
8 report is that the member gave two types of eye  
9 drops to a resident at the same time and  
10 disregarded the intervention or communication  
11 received from a family member.

12 I also see that the nurse has  
13 reported to the employer that it was a busy  
14 night, she was running late, and that she knows  
15 she shouldn't have done it.

16 And again, I would say that I  
17 would characterize this as a medication error,  
18 and that the nurse is identifying mitigating  
19 circumstances.

20 And I would also be mindful of  
21 my knowledge of long-term care settings and  
22 that it would not be unusual for a nurse to  
23 have a busy night and be running late. This is  
24 clearly a failure to meet standards and --

25 Q. And which standards in  
26 particular?

27 A. Medication standard, yes.

28 And again, I look at what action  
29 the employer took and would agree that that is  
30 appropriate action, and that would be my  
31 assessment of this incident.

32 I am trying not to get into how

1 I put them all together, so that would be my  
2 assessment.

3 Q. And in terms of your  
4 assessment of this incident, can you assist us,  
5 based on your experience reviewing these  
6 reports, how you would have assessed risk from  
7 this incident?

8 A. I would assess it as low.  
9 The nurse is acknowledging that it was  
10 inappropriate and is identifying that she knows  
11 she shouldn't have done it. So my assessment  
12 would be that there isn't a defensiveness or a  
13 disregard for the standard, but there is a  
14 failure to meet the standard.

15 Q. And over the page, please, to  
16 the incident of November 25th, 2013, and can  
17 you describe what you believe you would have  
18 understood from this incident and then go  
19 through the same process of advising, based on  
20 your experience considering these reports, what  
21 standards would have been implicated and what  
22 your assessment would have been?

23 A. In this incident, I am  
24 observing a number of things.

25 So the incident itself is that a  
26 urine sample was obtained. The member's  
27 responsibility was to test that through a test  
28 that is known as a dip test, so it is not going  
29 to a lab, but using a strip to test the urine,  
30 and that it was not completed and the urine  
31 sample had to be discarded because it was  
32 stale. So that is the incident.

1 I am also observing that it was  
2 the PSW who had the -- the member's response to  
3 the employer is that it was the PSW who had the  
4 idea to obtain a urine sample, and the member  
5 said she did not feel the doctors would do  
6 anything about it. That suggests to me that  
7 there is potentially some conflict between  
8 registered staff and unregistered staff over  
9 this incident.

10 And the employer's assessment  
11 indicates that work performance is not adequate  
12 and that other areas -- sorry, that this could,  
13 if there were further incidents, this would  
14 lead to further discipline up to and including  
15 termination. That is not uncommon for me to  
16 read that in a report where an employer has  
17 re-directed a member.

18 And then there is further  
19 examples of work performance not to standard;  
20 not doing assessments, processing and following  
21 up on doctors' orders and other work as  
22 required of registered staff is other  
23 information that is identified there.

24 Q. Okay, and in relation to that  
25 last element, based on your experience, Ms.  
26 Coghlan, what would your considerations have  
27 been in relation to the element that you just  
28 reviewed, the examples of work performance not  
29 up to standard, et cetera?

30 A. I would be looking at the  
31 whole report to see what those other examples  
32 were.

1 Q. Okay. So is it your evidence  
2 that you would have expected to see or you  
3 believe now -- I'm not going to ask that  
4 question.

5 Let's go to the next incident.  
6 So April 8th, 2013, on page 9, and if you can  
7 walk us through what you believe you would have  
8 understood with respect to this incident, Ms.  
9 Coghlan?

10 A. So this is an incident where  
11 medications were not given to a resident, and  
12 the resident was overlooked on two med passes,  
13 which is medication passes. That is the  
14 distribution of medications at an allotted  
15 time.

16 And it appears that - excuse  
17 me - that this is an example -- that the  
18 employer is identifying that the member did not  
19 follow proper electronic medication  
20 administration, drug administration practices.  
21 So those would be facility practices, and  
22 possibly as well as according to the College  
23 documentation standard.

24 I then look at the member's  
25 response to the employer, which is that she  
26 thought she had given them and that she is  
27 saying she does know how to give medication  
28 properly.

29 I would also be mindful again of  
30 the setting and the context, and my knowledge  
31 of long-term care settings is that there are  
32 many, many medications distributed to residents

1 and this is the kind of medication error that  
2 is very common. And it is also the kind of  
3 medication error that employers would typically  
4 deal with within this setting, both  
5 re-directing the nurse and also looking at the  
6 systems in place in the workplace to ensure  
7 that there are the appropriate supports for  
8 nurses to practice according to the standards.

9 Q. Ms. Coghlan, if you turn over  
10 the page now to page 10 and the incident of  
11 March 14th, 2013, which is the month prior to  
12 the last incident, and assist us with what you  
13 believe you would have understood with respect  
14 to this incident?

15 A. This is a medication incident  
16 as well, a narcotic being given but not signed  
17 for, and the member recalling later that she  
18 gave the narcotic - excuse me - the narcotic at  
19 the same time as she gave a Tylenol. And she  
20 didn't sign for it on the Medication  
21 Administration Record or on the narcotic sheet  
22 and gave the medication early.

23 I don't have any information  
24 about how early, and so that is a piece of  
25 information that is not particularly helpful in  
26 my assessment of that particular incident.

27 I also note that she  
28 acknowledges in retrospect, in responding to  
29 the employer's inquiries, that she did three  
30 things that contributed to the medication  
31 error.

32 And she received education on



1 proper medication administration as well as an  
2 employer sanction.

3 Q. And based on your experience  
4 reviewing these reports, Ms. Coghlan, what  
5 considerations would you have had in relation  
6 to this incident?

7 A. Well, one thing I would be  
8 looking for is I would look to see if there  
9 were any other narcotic issues that came out in  
10 the rest of the report and would want to  
11 determine whether there were other concerns  
12 involving narcotics or if this was simply an  
13 incident of a medication being given and not  
14 signed for.

15 Q. And why would that have been  
16 important?

17 A. Because narcotics are  
18 high-risk medications and they also -- issues  
19 with narcotics are often an indicator of a  
20 capacity issue with a nurse, so sometimes  
21 nurses who have substance use disorders are  
22 first identified through issues with narcotic  
23 administration in the workplace. And that is a  
24 high risk to patient safety, so it is in our  
25 risk assessment; it is one of the things that  
26 we are alert to.

27 Q. And in terms of your practice  
28 in assessing these reports and weighing that,  
29 whether or not you should be concerned about a  
30 narcotic issue, was it your practice to  
31 consider a member's prior history?

32 A. Yes, it was.

1 Q. And is it the case that if  
2 the member's prior history involved an  
3 incapacity issue, that might have some  
4 implications on your risk assessment?

5 A. It may if the incidents  
6 reported provided a concern that there was a  
7 similarity between the previous incapacity  
8 issue and the current report.

9 So this incident alone does not  
10 give me any indication of a link to a prior  
11 finding of incapacity.

12 Q. Okay, and why is that?

13 A. The -- it is a single  
14 narcotic. It is one medication, and it is not  
15 uncommon for nurses to miss documenting that a  
16 single medication has been administered when  
17 they are administering hundreds of medications  
18 in some instances.

19 And I don't see any other  
20 incident that tells me there is a trend or an  
21 ongoing -- a concern that always centres around  
22 the administration of narcotics; so for  
23 example, I saw eye drop administration, urine  
24 sample, those previous incidents that we have  
25 just walked through did not involve narcotics.

26 Q. Now, Ms. Coghlan, if you can  
27 turn to page 11, and in particular, the  
28 incident on February 12th, 2013, and if you can  
29 assist us with this incident, what you believe  
30 based on your experience you would have  
31 understood and what your considerations would  
32 have been?

1                   A. So my understanding or my  
2                   assessment of this incident would be that this  
3                   is a failure to follow the proper procedure for  
4                   medication administration and medications are  
5                   left at the dining room table.

6                   This -- part of my assessment  
7                   would be through my experience that this is a  
8                   very common happening in long-term care, and it  
9                   is something that happens in a busy setting  
10                  where there are, in many cases, only one  
11                  registered staff available at the time who can  
12                  very easily be distracted during medication  
13                  administration. So for example, a patient can  
14                  fall. The nurse is in the process of  
15                  administering medication and is called away to  
16                  deal with the fall and may inadvertently leave  
17                  the medication at the dining table.

18                  It does pose a risk to -- a  
19                  potential risk to clients, and that is why it  
20                  would be characterized as a medication error.

21                  Q. And in terms of the level of  
22                  risk, what do you believe your assessment would  
23                  have been about the level of risk?

24                  A. I would have assessed this as  
25                  low, low risk, and again, that it was  
26                  appropriately dealt with in the workplace.

27                  Q. Over the page now, please,  
28                  Ms. Coghlan, to page 12, and if you could  
29                  assist us with what you believe you would have  
30                  understood in relation to this incident and  
31                  what you believe your considerations would have  
32                  been?

1                   A. This incident is a report of  
2                   not taking medication refrigerator temperatures  
3                   and vaccine medication refrigerator  
4                   temperatures and narcotics not properly counted  
5                   with the oncoming shift.

6                   And then the response being that  
7                   it suggests to me that there has been a recent  
8                   change in the procedure for narcotic count and  
9                   the member is indicating she forgot to take  
10                  fridge temperatures.

11                  So one of the things that I'm  
12                  considering when looking at this incident is,  
13                  again, in terms of a risk assessment, nurses in  
14                  long-term care often are assigned by their  
15                  employer activities that are not within the  
16                  scope of nursing practice, and so that is an  
17                  employer/employee matter and I would put  
18                  checking fridge temperatures in that category.

19                  And the employer has taken  
20                  action on that, and that the employer has also  
21                  ensured that there has been a review of the  
22                  proper procedure for narcotic count and a  
23                  review of their other policies and procedures  
24                  in relation to fridge temperatures.

25                  I am also at this point, I have  
26                  been through a number of incidents in my  
27                  review, because that is the way I typically  
28                  review them, is from the most recent through  
29                  the history, and I am seeing this as low risk  
30                  and kind of questioning myself. So this was  
31                  September 2012, and I am not really sure why an  
32                  employer is reporting this to the College as a

1 serious concern.

2 Q. Which part in particular were  
3 you --

4 A. The fridge temperatures.

5 Q. I see, okay. And now,  
6 finally, to the incident at page 13, and this  
7 is an incident of August 29th, 2012.

8 A. And this is an example -- an  
9 incident, rather, of the nurse not assessing a  
10 resident when required. I don't have any other  
11 information about what the requirement was at  
12 the time, other than that the resident was not  
13 herself at the time. However, there was no  
14 adverse event.

15 And then I look at the member's  
16 response to the employer, and it tells me that  
17 she didn't follow through on assessing a  
18 resident and her reason was that she wasn't  
19 feeling well herself and that she has worked  
20 through the module on professionalism from the  
21 College's website on her own initiative.

22 Q. And when you indicated  
23 earlier that you didn't have further  
24 information in terms of this incident, is the  
25 College able to make inquiries if they feel  
26 that they need further information?

27 A. Yes.

28 Q. And do you know whether  
29 further inquiries were made with relation to  
30 this incident?

31 A. There was an -- during the  
32 intake process, the Intake Investigator would

1 make inquiries about the whole report, and so  
2 that is why I would be going to the interview  
3 summary to determine whether there was any  
4 additional information that would assist me in  
5 assessing the overall risk.

6 Q. Okay. And then finally, on  
7 the very last page, page 14, there is a final  
8 line in this report, and if you can assist us  
9 in the same way, please?

10 A. The final summary statement  
11 is that:

12 "There were other reports from  
13 staff that did not lead to  
14 discipline but were considered  
15 at [the] time of termination."

16 In the absence of any other  
17 information, I would interpret that to mean  
18 that the employer didn't feel that those were  
19 nursing issues, but rather issues to be dealt  
20 with within the workplace and could be things  
21 related to conflict between staff members in  
22 the workplace.

23 And then the next line is:

24 "These reports had to do with  
25 attendance [and] professional  
26 behaviour."

27 So that tells me that there may  
28 have been some labour relations -- human  
29 resource issues in terms of which are things  
30 that we see employers sometimes reporting,  
31 nurses not available for work or arriving late,  
32 those kinds of things.

1 Q. And what is it, based on this  
2 sentence, that would cause you to reach that  
3 understanding that it is a human resources  
4 issue?

5 A. I don't draw any conclusion.  
6 What it is telling me is that the employer has  
7 satisfied themselves that this information is  
8 not information that would assist the College  
9 in assessing the risk that a nurse's practice  
10 poses to residents.

11 And that is the assessment we  
12 count on employers to make, to determine the  
13 information that the regulator needs in order  
14 to form an assessment and determine an  
15 appropriate regulatory response.

16 MS. JONES: We just need a  
17 moment, Madam Commissioner, for  
18 the court reporter.

19 THE COMMISSIONER: Thank you.

20 -- RECESSED AT 11:48 A.M.

21 -- RESUMED AT 11:48 A.M.

22 BY MS. JONES:

23 Q. Thank you. Now, Ms. Coghlan,  
24 was it your evidence that you believe you would  
25 have also reviewed the interview summary  
26 between Ms. Yee and Ms. Crombez?

27 A. Yes.

28 Q. Okay. And if you can turn  
29 that up, please, that's at tab 39, and it's  
30 Document 36847. And I take it, like the  
31 report, you have no recollection of actually  
32 reviewing this memo?

1 A. At the time, no.

2 Q. Okay. So I'm just going to  
3 ask you, having a look at this memo now, if you  
4 can assist us with, based on your experience  
5 reviewing these reports what considerations you  
6 would have had and what assessment you would  
7 have made of the information contained in this  
8 memo or this interview summary, rather?

9 A. So one of the things I  
10 typically look for when reviewing the interview  
11 summaries is, is there additional information  
12 that has been gleaned through the interview  
13 with the employer that can assist the College  
14 in conducting the risk assessment?

15 And so as I work through --  
16 first of all, we note she hasn't worked  
17 anywhere else, to the knowledge of this  
18 employer, since 2005, and that the employer is  
19 not aware of whether the member had any  
20 stressors going on in her person life that may  
21 have affected her practice.

22 So that statement is giving me  
23 additional information upon which to consider  
24 the previous health inquiry incident from 1995.  
25 And then there's no underlying issue or concern  
26 with the member again, so we're not getting  
27 additional information from the employer beyond  
28 the incidents reported.

29 In the next bullet, the employer  
30 relates that one time "a while back," so this  
31 is not a current recollection of the  
32 employer or a current experience of the



1 employer. It's not at a current point in time.

2 But a while back, she recalls  
3 that the member mentioned she was on medication  
4 for some mood-related or anxiety condition and  
5 that she had recently changed her medication,  
6 was having difficulty adjusting to it, and that  
7 that was the reason for an error that she made.

8 The reported incidents go back  
9 to 2012, and prior to 2012, the member worked  
10 in another section and that in 2012, the member  
11 started in a new section, only working evening  
12 shifts.

13 I'm assessing that we have a  
14 two-year period, roughly, here and that this  
15 director of nursing is commenting on the  
16 incidents that have occurred in that two-year  
17 period.

18 Q. Okay. And just stopping you  
19 there, in relation to the member mentioning  
20 that she was on medication or it being reported  
21 in this interview that the member referred to  
22 being on medication for some mood-related  
23 anxiety condition, that she'd had her  
24 medication changed and she was having  
25 difficulty adjusting to it, could those  
26 considerations or could that sort of  
27 information have had an impact in relation to  
28 an assessment of capacity for this member?

29 A. Well, on their own, no. Many  
30 nurses are on medications, and they have no  
31 impact on their ability to practice.

32 They may have a single incident,

1 as this individual identified, but what I'm  
2 also looking at is -- because incapacity is a  
3 current state. So I have to form the belief  
4 that a nurse is currently impacted by a health  
5 condition. And so I'm going back to the notes  
6 where the employer has reported that they're  
7 not aware of any stressors and no underlying  
8 issue or concern with the member.

9 So I'm satisfied that this one  
10 time a while back was indeed a one-time because  
11 there isn't any other additional information.

12 Q. And I think you were -- you  
13 had reviewed most of the top part of this,  
14 Ms. Coghlan, and I'm interested in what you  
15 believe your assessment would have been in  
16 relation to the incident about the UTI at the  
17 bottom of the page.

18 A. Well, this is an example of  
19 sloppy nursing practice that falls below the  
20 standard for the therapeutic nurse-client  
21 relationship, poor communication with the  
22 family, and again, I would look at this in  
23 relation to the incident in the employer report  
24 as well. But my assessment, looking at this,  
25 is that this falls below the standards.

26 Q. Okay. And which standards in  
27 particular would you have -- does this  
28 fall below?

29 A. Professional standards and  
30 the therapeutic nurse-client relationship.

31 Q. And then over the page,  
32 Ms. Coghlan, anything in relation to the

1 information at the end of the interview that  
2 you believe would have played a role in your  
3 assessment?

4 A. Yes, one of the things that  
5 I'm looking for is what is the member's  
6 response when gaps in practice are brought to  
7 her attention, and this is telling me that she  
8 was always upfront about her errors. She would  
9 say she didn't mean to make them. She never  
10 denied the incidents, always took ownership of  
11 them, and she accepted that she made a mistake.

12 And then the comment, "the  
13 member just never changed her practice"  
14 suggests, potentially, that this is an employer  
15 who is frustrated and has had enough with this  
16 sloppy practice, as I would characterize it.

17 There was no sustained harm to  
18 residents involved in the incidents, and I do  
19 look -- I look at that, but I also look at the  
20 potential risk of harm. So it isn't just  
21 whether it was sustained, which, in this case,  
22 it was not, but I also look at whether there  
23 was a serious or potential risk of harm with  
24 the practice described.

25 And that the member could be  
26 very pleasant with residents, that her focus  
27 was more being friends with her co-workers than  
28 working, and I see that as corroborating the  
29 statement at the end of the report where there  
30 had been complaints from her colleagues and  
31 other incidents that the employer had not  
32 detailed in the report because they related to

1 attendance and behaviour. And that she was  
2 always respectful and nice, but her practice  
3 never changed.

4 Q. And do you believe based on  
5 your experience reviewing these reports that  
6 you would have had concerns about the fact that  
7 Ms. Crombez was reporting the fact that the  
8 member's practice never changed when these  
9 issues were raised with her?

10 A. That does factor in. What  
11 also factors in are the practice setting and  
12 the -- whether there's any reported insight  
13 from the member.

14 Q. And now, Ms. Coghlan, if you  
15 can turn to Ms. Yee's memo, which is at tab 40  
16 of your document brief, and this is  
17 Document 36833. If you can turn to the third  
18 page of that document first, please -- and if  
19 you go down a little bit more, please -- whose  
20 handwriting is that at the bottom?

21 A. That's mine.

22 Q. And so what does that  
23 handwriting indicate?

24 A. So there's the date upon  
25 which I've reviewed this file. I am indicating  
26 I agree with the recommendation from the intake  
27 investigator, and those are my initials.

28 Q. Now, if we look at this, back  
29 to the first page of this memo, do you believe  
30 that you would have reviewed this memo?

31 A. Absolutely.

32 Q. Okay. And if we look at the

1 very top, it says:

2 "Note: This memo to file has  
3 been done in lieu of Webart."

4 Can you assist us with what that  
5 means?

6 A. So these were the early days  
7 in this switching from the printed tool that we  
8 discussed this morning, and there were still  
9 some files that I was getting that may have  
10 been using that tool. And so this is the  
11 investigator just noting that this is the new  
12 format that I'm seeing.

13 Q. And we see that it begins  
14 with some background information about the  
15 member, and then under "Prior," is it fair to  
16 say that that is a summary of what would have  
17 been in the College's Geraldton file?

18 A. That's correct.

19 Q. And when earlier you gave  
20 evidence that you would have obtained  
21 information about that incident from this memo,  
22 is this the information you would have  
23 received?

24 A. Yes. And now that I see  
25 this, I am confident that I did have the  
26 original file because the investigator would  
27 have had the original file in order to complete  
28 this assessment, and if the file was available,  
29 I received it.

30 Q. And as part of your  
31 assessment of risk, would you have considered  
32 the information about this prior capacity

1 issue?

2 A. Yes, I would.

3 Q. And then we see that there is  
4 a summary, then, of the incidents?

5 A. Yes.

6 Q. And we've just gone through  
7 those; we won't do that again. And then  
8 there's a reference on page 2 to the fact of  
9 the interview with Ms. Crombez, which we've  
10 looked at, and there's then a section entitled  
11 "Assessment," correct?

12 A. Yes.

13 Q. And in the assessment  
14 section, Ms. Yee has written that:

15 "The nursing issues mainly  
16 concern the member's medication  
17 administration skills and, to a  
18 lesser degree, the member's TNCR  
19 skills."

20 What's TNCR?

21 A. TNCR is the therapeutic  
22 nurse-client relationship.

23 Q. And having refreshed your  
24 memory of looking through the report and the  
25 materials, do you agree that those are the  
26 standards that are implicated in the report?

27 A. Yes.

28 Q. And then Ms. Yee has  
29 indicated from February 2013 to March 2014, the  
30 member made seven medication errors, and then  
31 she provides examples of those medication  
32 errors, correct?

1 A. Yes.

2 Q. And then Ms. Yee indicates  
3 that there were two incidents where the  
4 member's interactions, communications with  
5 either resident or residents' family made them  
6 upset, and she summarizes those as well?

7 A. That's correct.

8 Q. And then -- and she says, I  
9 apologize, at the end of that first paragraph  
10 on that page:

11 "There was no sustained harm to  
12 the residents"?

13 A. That's correct.

14 Q. And then she goes on to refer  
15 to the fact that according to the director of  
16 nursing:

17 "The member always took  
18 ownership of her errors,"  
19 and having reviewed the report  
20 again and the materials again, is that your  
21 view as well?

22 A. Yes.

23 Q. And then there's the  
24 reference to a mood or anxiety condition?

25 A. Yes.

26 Q. And you've given evidence  
27 about what consideration that would have had.

28 And then in the last paragraph  
29 above "Recommendation," Ms. Yee says the  
30 member's prior occurred 17 years ago. And the  
31 member's "prior," what is that?

32 A. That is the incapacity

1 proceeding with the College --

2 Q. And that --

3 A. -- in nine -- resulting from  
4 the 1995 report from the Geraldton Hospital.

5 Q. Okay. And she writes:

6 "Although the member's prior is  
7 related to health, the  
8 information in this current  
9 report does not indicate that  
10 the member's health is a current  
11 issue."

12 A. And I agree with that.

13 Q. Okay. And why do you --  
14 what's the basis of your agreement with that?

15 A. There's no indication that  
16 there is an ongoing health issue that is  
17 negatively affecting her practice.

18 Q. And in terms of your  
19 experience in looking for that or considering  
20 that, what types of factors would you have  
21 considered in determining whether or not there  
22 was an ongoing health issue?

23 A. The only way in many way -- I  
24 guess I need to say the majority of ways that  
25 the College gets information about a current  
26 health condition is through the employer. So  
27 employers are very attuned to and are in the  
28 best position because they are observing  
29 practice at the point of care, and the College  
30 relies on the report of an employer.

31 And my assessment of the  
32 information that I had indicated that the



1 employer had lots of opportunity to identify  
2 whether there were any other concerns, and  
3 there is no information to suggest that.

4 The one reference to "sometime a  
5 while back" was not an indication of a health  
6 condition that was currently having an impact  
7 on practice and did not raise an alarm.

8 If there'd been other  
9 information that, you know, the member -- so  
10 that last incident, if the member -- at that  
11 point in time, which was close to the time of  
12 the report that the employer had indicated, I  
13 think there's -- that her own health is  
14 continuing to be an issue, something like that,  
15 that would have prompted further inquiry.

16 Q. And what about in that regard  
17 the fact that two of the incidents involved  
18 narcotics?

19 A. There is no indication of  
20 narcotics being misappropriated or narcotics  
21 going missing in the workplace.

22 And as I said, we look carefully  
23 whenever we see -- whenever I see the word  
24 "narcotic," I look carefully to see what it is  
25 in relation to, and in these incidents, they  
26 are not associated with any systemic workplace  
27 concern that their narcotic counts are always  
28 off or whenever this member is on, there's a  
29 problem with narcotics missing. Those kinds of  
30 things are the kinds of things that I would be  
31 looking for.

32 Q. Okay. And then under

1 "Recommendation," it says "bank with notice,"  
2 and "Review: PS meds." If you could explain  
3 what "bank with notice" means?

4 A. All right. So the first  
5 consideration that I make when conducting --  
6 after conducting my assessment is, is there  
7 action warranted? Should the College -- does  
8 the College have information that warrants some  
9 regulatory action? And my assessment in this  
10 case would be yes, and that coincides with the  
11 assessment of the investigator.

12 The specific recommendation  
13 "bank with notice" is an internal term that we  
14 use, and it refers to the fact that the member  
15 needs to be notified that the College has this  
16 information, notified of the concerns that the  
17 information raises, and directed -- reminded of  
18 their professional accountability, and then  
19 directed to review standards that relate to the  
20 incident.

21 And in reminding them of their  
22 professional accountability echoes back to  
23 their accountability for continued reflection  
24 and identification of opportunities to improve  
25 practice.

26 The letter is signed by me, and  
27 it is intended to be remedial. It has language  
28 that is consistent with a remedial approach;  
29 however, I can tell you that if you were to ask  
30 a nurse who received that letter, they would  
31 consider it a warning. So nurses take very  
32 seriously receiving a letter from the College,

1 and in this case, my overall assessment of all  
2 of the incidents suggested that this approach  
3 was the appropriate level of regulatory action.

4 Q. And after you signed your  
5 agreement with this recommendation,  
6 Ms. Coghlan, a letter was then sent to  
7 Ms. Wettlaufer, correct?

8 A. That's correct.

9 Q. Okay. And you referred to  
10 that letter that's at tab 41, Document 36840,  
11 and is this the letter that you were referring  
12 to?

13 A. Yes, it is.

14 Q. Okay. And in this letter, in  
15 the first line of your letter, you indicate  
16 that the College has received information from  
17 Caressant Care, correct?

18 A. That's correct.

19 Q. Okay. So would this be the  
20 first advice or notice to Ms. Wettlaufer of  
21 this matter?

22 A. Yes, it would be.

23 Q. Because I noted in the file  
24 there's no response from Ms. Wettlaufer about  
25 the incidents.

26 A. No. This went through the  
27 intake process of assessment, and there was no  
28 interaction with the member.

29 Q. And in the second paragraph,  
30 there's a paragraph about Ms. Wettlaufer's  
31 prior history with the fitness to practice  
32 committee. Why is it the College's practice to

1 include that sort of information, if that is  
2 the College's practice?

3 A. It is the College's practice  
4 and that is because we are being very  
5 transparent with members about the fact that  
6 the information the College has about them  
7 throughout their career is retained on file.  
8 And you will note at the end of my letter, I  
9 also advise her that this current matter is  
10 being kept on file.

11 So it is reminding members of  
12 their accountability and the role of the  
13 College in ensuring that they are aware of  
14 their accountability to practice safely.

15 Q. And then in the next  
16 paragraph, you point out that as executive  
17 director, you have the discretion to appoint an  
18 investigator to investigate Ms. Wettlaufer's  
19 conduct?

20 A. That's correct.

21 Q. If you believe on reasonable  
22 and probable grounds that she had committed an  
23 act of professional misconduct or that she was  
24 incompetent, and that you determined that the  
25 appointment of an investigator was not  
26 currently warranted, correct?

27 A. That's correct.

28 Q. Okay. So just to be clear,  
29 on the basis of the information you had, one  
30 option you would have had or you could have  
31 taken would have been to appoint an  
32 investigator and to have conducted a formal

1 investigation?

2 A. That is an option. As I  
3 indicated, the risk assessment guides the level  
4 of regulatory force, if you will -- I say  
5 regulatory action -- that is appropriate and  
6 proportionate to the risk that is posed by the  
7 member's practice.

8 Q. Okay. And you've gone  
9 through in relation to individual incidents  
10 what your risk assessment was. Can you assist  
11 us based on your experience reviewing these  
12 reports what you believe your risk assessment  
13 would have been as a whole, the entire picture  
14 from the information that you received?

15 A. My assessment is that this is  
16 a nurse who over a period of time had a number  
17 of what I call low-risk incidents that suggest  
18 sloppy practice, and there also is a suggestion  
19 that, for whatever reason, the nurse is not  
20 responding to this employer's expectations and  
21 direction and that the nurse is -- I'm sorry,  
22 now I'm losing what your original question was.  
23 Was the assessment -- overall assessment of  
24 risk?

25 Q. Yes.

26 A. Yes, thank you. And that the  
27 nurse needs to be reminded of her professional  
28 accountability and the College's expectations.

29 Q. And you've referred to  
30 "sloppy practice." Do you believe that it was  
31 your assessment that Ms. Wettlaufer's practice  
32 overall was sloppy?

1                   A. I think there were examples  
2 of sloppy behaviour. There were also examples  
3 of poor communication and what we --  
4 medication errors.

5                   Q. And do you believe, based on  
6 your experience in reviewing these reports,  
7 that you would have had any concerns about  
8 Ms. Wettlaufer's ability to administer  
9 medication safely?

10                  A. No. When I looked at the  
11 medication errors in total, they were typical  
12 of medication errors that are low-risk and are  
13 amenable to remediation, review of standards,  
14 and attention to one's professional  
15 accountability.

16                  Q. And again, based on your  
17 experience reviewing these reports, do you  
18 believe it would have been your impression that  
19 Ms. Wettlaufer was practicing within the  
20 standards of the profession?

21                  A. She was practicing at the low  
22 end of the standards, I would say, and that  
23 there were examples where she didn't practice  
24 according to standards, and that is not  
25 uncommon in the reports that the College  
26 receives. I think the employer used the term  
27 that her performance was "inadequate" at one  
28 point, and so that was a characterization of  
29 her work.

30                  Q. Ms. Coghlan, turning now, and  
31 we'll do this very briefly -- this information  
32 is in the Overview Report, but for the benefit

1 of the public -- to the College's process upon  
2 learning of Ms. Wettlaufer's confession.

3 Am I correct that in  
4 September 2016, the College was contacted by a  
5 physician at the Centre for Addiction and  
6 Mental Health and advised of Ms. Wettlaufer's  
7 confession?

8 A. That's correct.

9 Q. Okay. And had the College  
10 ever addressed or dealt with a matter of this  
11 scale before?

12 A. No.

13 Q. And am I correct that the  
14 College, on September 30th, made an emergency  
15 appointment of investigators under the Code?

16 A. That's correct.

17 Q. And were any terms,  
18 conditions, or limitations placed on her  
19 certificate of registration at that time?

20 A. At that time, they weren't,  
21 but the intake investigator assured herself  
22 that the member was not in a position to  
23 practice. She was hospitalized --

24 Q. Okay.

25 A. -- and under police guard.

26 Q. Okay. And could any terms,  
27 conditions, or limitations have been placed on  
28 her certificate at that time?

29 A. Not under our legislative  
30 scheme, no --

31 Q. Okay.

32 A. -- at that point.

1 Q. At that point. And has that  
2 legislative scheme changed?

3 A. Yes, it has.

4 Q. And so now under the current  
5 legislation, if information of this sort comes  
6 to a regulator's attention, can terms,  
7 conditions, and limitations be placed on the  
8 certificate of registration of the member?

9 A. Yes, they can.

10 Q. And is that on an emergency  
11 basis?

12 A. Yes.

13 Q. And --

14 A. We could do what we call an  
15 "interim suspension," and that would show on  
16 the public register.

17 Q. Okay. And in terms of the  
18 public register, if you can turn to tab 43 of  
19 the document brief, which is Document 71068,  
20 and is this a printout from the public  
21 register?

22 A. Yes, it is.

23 Q. And this printout shows that  
24 Ms. Wettlaufer was not entitled to practice?

25 A. That's correct.

26 Q. And that she had resigned?

27 A. That's correct.

28 Q. And do you know when the  
29 College's public register was updated to  
30 reflect that information?

31 A. I believe it was October 14th  
32 of 20... What year are we here?



1 Q. 2016.

2 A. 2016, thank you.

3 Q. And how do you determine a  
4 that? I can't see a date on the document.

5 A. That's my recollection. It's  
6 not indicated here from our College records  
7 that the date -- that the record was updated  
8 was October 14th.

9 Q. I --

10 A. The date of her -- sorry.

11 Q. I think that's helpful. So  
12 from the College record, it's your  
13 understanding that that's the date?

14 A. That's the date that the  
15 public register was updated, yes.

16 MS. JONES: Okay. Thank you,  
17 Ms. Coghlan. I have no further  
18 questions.

19 THE WITNESS: Thank you.

20 THE COMMISSIONER: Thank you  
21 very much, Ms. Jones.

22 MS. ROTHSTEIN: So I believe  
23 that Madam Registrar has a brief  
24 to hand up to Ms. Coghlan and  
25 the Commissioner.

26 THE COMMISSIONER: Thank you.

27 THE WITNESS: Thank you.

28 CROSS-EXAMINATION BY MS.

29 ROTHSTEIN:

30 Q. So, Commissioner,  
31 Ms. Coghlan, I just want to begin by touching  
32 on a few of the points that you gave evidence

1 about yesterday with Commission Counsel,  
2 particularly at the end of the day where there  
3 may have been a little lack of clarity in some  
4 of the evidence that you gave.

5 And I want to talk about the  
6 Geraldton events that led to the College's  
7 incapacity fitness to practice investigation  
8 back in 1995. You remember giving evidence  
9 about that, Ms. Coghlan?

10 A. Yes.

11 Q. So you were also asked at the  
12 end of your evidence to talk about the kind of  
13 information following a fitness to practice  
14 finding of incapacity that makes its way to the  
15 public register, and I want to ask you to go to  
16 your affidavit, if you would, paragraphs 52  
17 and 53, where that is set out in some detail.

18 You'll find paragraph 53 at  
19 page 23 of your affidavit, Ms. Coghlan.

20 A. Yes.

21 Q. And it reads that:

22 "The following information about  
23 Ms. Wettlaufer would therefore  
24 have been available to the  
25 public on the public register at  
26 the following periods of time,"  
27 and this is after there has been  
28 a finding of incapacity.

29 So you make the note there, and  
30 you indeed told the Commissioner about this  
31 that for a year from May 9th, 1997, to May 9th,  
32 1998, the restrictions that were imposed on her

1 certificate and what those restrictions were.  
2 You remember testifying about that?

3 A. Yes.

4 Q. But with respect to the  
5 incapacity finding itself -- leave aside the  
6 issue of restrictions -- am I correct that even  
7 back in 1995, that was posted on the College's  
8 register in accordance with the legislation for  
9 a much longer period of time?

10 A. Yes, you are correct. There  
11 have been so many changes to the register, I  
12 apologize if my response was misleading.

13 Q. Okay.

14 A. At that period of time, I  
15 believe that the legislation indicated that  
16 that -- the fact of the incapacity finding  
17 would stay on for six years.

18 Q. So that for a full six years,  
19 even after the expiry of the terms, conditions,  
20 and limitations any employer who chose to  
21 search the public register would have learned  
22 that Ms. Wettlaufer had indeed been found to  
23 have been incapacitated by the fitness to  
24 practice committee?

25 A. That's correct.

26 Q. All right. And I understand  
27 that in 2009, so we'll come to that change.  
28 That six-year limitation changed; is that  
29 right?

30 A. That's right.

31 Q. And what is it since 2009?  
32 How long is the fact of the incapacity finding

1 on the public register?

2 A. It stays on permanently.

3 Q. It stays on permanently.

4 A. Yes.

5 Q. That's helpful. And then,

6 Ms. Coghlan, you mentioned in response to  
7 Ms. Jones's questions yesterday that while  
8 there isn't an actual statutory requirement  
9 that members self-report health issues to their  
10 regulator that there were ethical standards  
11 that require nurses to remove themselves from  
12 the practice where they viewed their health as  
13 having some impact on their practice; you  
14 remember mentioning that?

15 A. That's correct.

16 Q. And I think you were at a  
17 loss to identify the specific ethical standard.

18 And so, Commissioner, really  
19 just to help you as to where to find it, it's  
20 part of the Overview Report, and I believe  
21 we've given you a paper copy of the Ethics  
22 Practice Standard. And if you look -- and,  
23 Ms. Coghlan, I hope you have one too --

24 A. Yes.

25 Q. -- I believe that we're  
26 talking about -- so it's 55053, and I believe  
27 that we're looking at page 10 in the top  
28 left-hand corner and under "Behavioural  
29 Directives"?

30 A. Yes.

31 Q. And that bullet point reads  
32 that:

1 "Nurses demonstrate a regard for  
2 maintaining commitments to  
3 themselves by recognizing their  
4 physical and mental limitations  
5 and the impact their own health  
6 has on their ability to provide  
7 safe, effective, and ethical  
8 care"?

9 A. That's correct.

10 Q. So I understand that the  
11 notion is that quite apart from the legislative  
12 regime, the College creates a number of ethical  
13 obligations for nurses, right?

14 A. That's correct.

15 Q. And broadly speaking, those  
16 ethical obligations require nurses to be  
17 self-reflective not only about their practice  
18 but also about their health?

19 A. Absolutely.

20 Q. And to take appropriate  
21 action in those circumstances, right?

22 A. That's correct.

23 Q. And, Ms. Coghlan, just so  
24 those who aren't familiar with some of the  
25 language that you use repeatedly in your  
26 evidence and is of course second nature to you,  
27 that's what you talk about when you talk about  
28 professional nurses having responsibilities to  
29 be accountable; is that right?

30 A. Yes.

31 Q. Okay, thank you. And I also  
32 want to talk to you about another interesting

1 feature of the evidence that Commission Counsel  
2 asked you about yesterday dealing with  
3 registration and the challenges of the  
4 College's oversight of the registration  
5 process.

6 And you'll recall that you told  
7 Commission Counsel yesterday that the  
8 registration process is a very significant  
9 undertaking of the College because you have 10  
10 to 13,000 nurses, is that right --

11 A. That's right.

12 Q. -- that are applying for  
13 licensure; is that right?

14 A. Yes.

15 Q. Per year?

16 A. Yes.

17 Q. Okay. Significant amount of  
18 work involved in doing that, I take it?

19 A. Yes.

20 Q. Okay. And you described  
21 again for Commission Counsel the kinds of  
22 things that the College currently does  
23 independently verify, and there's a number of  
24 things that the College goes about  
25 independently verifying before it actually  
26 provides a certificate of registration to a  
27 nurse?

28 A. That's correct.

29 Q. But she pointed out, and  
30 fairly, that all of the features of the license  
31 application that say, no, I haven't been found  
32 guilty of professional misconduct somewhere

1 else in the world; no, I haven't engaged in any  
2 act of dishonesty, that sort of thing, you do  
3 not independently verify apart from what you  
4 can do by a criminal records check. Have I got  
5 your evidence correctly?

6 A. That's correct.

7 Q. All right. So can you assist  
8 the Commissioner with, first of all, currently,  
9 the extent to which you view the ability to  
10 independently verify those other issues as  
11 something within the College's capabilities and  
12 what you see in the future about that?

13 A. So currently, that would be a  
14 very onerous, intensive process, and it is not  
15 something that is logistically possible.

16 Q. And do you know of any other  
17 regulator that does any such independent  
18 verification of those sorts of issues  
19 currently?

20 A. I don't know of any other  
21 regulator who does not access to a database who  
22 is able to do that, and that goes to what we  
23 are currently working on.

24 So currently, the College of  
25 Nurses of Ontario in collaboration with the  
26 College of Registered Nurses in British  
27 Columbia have been working collaboratively with  
28 the National Council of State Boards of Nursing  
29 to replicate a database that exists now in the  
30 United States, to create that database in  
31 Canada to allow regulators to have one place  
32 where registration and discipline history is

1 available to all regulators, anybody who's ever  
2 been registered or licensed. In our case, it  
3 will be in Canada.

4 The first step in that piece of  
5 work is creating a unique identifier. So right  
6 now, hypothetically, Anne Coghlan could be  
7 registered in three provinces in Canada, and  
8 you wouldn't know that the Anne Coghlan in  
9 Alberta is the same one as the Anne Coghlan in  
10 Nova Scotia or the same one who's also  
11 registered in Florida and California.

12 What we will have, and we're  
13 getting closer, is we will have a way to assign  
14 a unique identifier to everyone who ever  
15 becomes for the first time a nurse in Canada.  
16 And that will allow us to create a database, a  
17 regulatory database that will allow regulators  
18 to have immediate access to information about  
19 anyone who is applying for the first time to  
20 receive licensure or registration.

21 The other very exciting piece of  
22 this project is that there will be a capability  
23 to connect the databases between Canada and the  
24 U.S. So the data needs to reside in the  
25 individual countries, but regulators in the  
26 United States will be able to access  
27 information about nurses registered in Canada,  
28 and Canadian regulators will also be able to  
29 access information about nurses licensed in the  
30 United States.

31 And then finally what I'd say is  
32 that part of our international work is to look



1 at what is the potential in the future to  
2 create an international database because with  
3 increasing mobility of the nursing profession,  
4 which is not unique to nursing -- it's a  
5 feature of a lot of professions -- in terms of  
6 being able to ensure public safety, there's an  
7 increasing need for regulators to have ready  
8 access to data that will assist them in the  
9 decision-making that they make about individual  
10 applicants or individual members.

11 Q. And what do you think the  
12 timing is on that? What's your estimate?

13 A. Well, our hope is for Ontario  
14 and British Columbia -- we're doing the  
15 prototype, and it's a huge piece of -- it's  
16 very expensive, but we really feel it is an  
17 absolutely critical piece of work. We're  
18 hoping to have that by 2020, late 2019 or early  
19 2020, and then depending on the ability of  
20 other jurisdictions in Canada to link in, and  
21 that really is a resource issue.

22 So small provinces will need to  
23 secure, probably, government support in order  
24 to participate in the database, but we are  
25 convinced that it is a matter of public safety,  
26 and we will assist small provinces -- we are  
27 assisting them by funding the initial  
28 development of this project, and we will assist  
29 them to secure other sources of funding if  
30 necessary.

31 Q. Okay. Different topic but  
32 again touched on yesterday in your evidence,

1 and it was with respect to the issue of in what  
2 circumstances a regulated nurse can delegate to  
3 a non-regulated health professional, things  
4 like medication administration, and you  
5 described the situation in which it's assisting  
6 a person with his or her routine, activities of  
7 living.

8 And I just wanted to clarify,  
9 Ms. Coghlan, with you that that's something  
10 that isn't a College standard or just a College  
11 view; that actually reflects the legislation  
12 yet again. Am I correct about that?

13 A. That's correct.

14 Q. And that when you talk about  
15 those acts that can be delegated, those are  
16 specifically described in the RHPA?

17 A. That's correct.

18 MS. ROTHSTEIN: And just for  
19 your benefit, Commissioner, you  
20 can make a note that you can  
21 find the two relevant sections  
22 at tab 1 of your legislative  
23 binder. It's Section 29,  
24 subsection 5 of the RHPA, which  
25 you'll find at page 1856 and  
26 subsection 35 of the RHPA at  
27 page 1857.

28 THE COMMISSIONER: Thank you.

29 BY MS. ROTHSTEIN:

30 Q. I want to turn to an issue  
31 now that is obviously important for the  
32 Commissioner to know and understand perhaps a

1 little bit more about than you've already  
2 described, and that's the whole issue of  
3 mandatory reports and the form that they take  
4 and the kinds of information that the College  
5 expects employers to provide.

6 And you've touched on this with  
7 Commission Counsel, but you've made clear that  
8 given the current technological limits of the  
9 College, you expect those reports to be done by  
10 mail or by fax. But what happens if an  
11 employer phones or sends an e-mail?

12 Can you just describe to the  
13 Commissioner what the response of the College  
14 is in those circumstances?

15 A. So phone calls and e-mails  
16 are followed up on, and we retain those  
17 documents, and then we ask the reporter or the  
18 inquirer -- individual who has phoned or  
19 e-mailed to submit a report using the College's  
20 report form.

21 So there is always a response to  
22 an e-mail or a phone call. And they are often  
23 to assist -- those calls are often to assist  
24 the employer in their assessment of whether  
25 they have an obligation to make a report, and  
26 College investigators assist them to understand  
27 what their obligation is, but they're very  
28 clear that the decision rests -- that it's the  
29 accountability of the employer or facility  
30 operator to make that determination.

31 Q. Okay. And then I want to  
32 talk about in light of, particularly, your

1 evidence yesterday that I'm sure all ears  
2 pricked up over that there's quite a  
3 significant increase in the number of reports  
4 from employers that you are getting or just  
5 reports generally and how you are dealing with  
6 that increase in reports and how you determine  
7 which one comes first, which comes second, how  
8 long it takes you to get back to employers, how  
9 the College is managing that very significant  
10 responsibility to deal with reports as soon as  
11 possible?

12 A. So we have added additional  
13 resources, but we have also added some other  
14 steps in our process; so, for example, there is  
15 an immediate review of anything that comes up,  
16 and a very quick look to see is this a matter  
17 of high risk?

18 And by high risk, I mean matters  
19 that relate to abuse, whether it be physical  
20 abuse, mental abuse, sexual abuse, verbal  
21 abuse; matters where a nurse is recklessly  
22 disregarding the confidentiality and privacy of  
23 clients, so unauthorized access of health  
24 records; sexual abuse. Very serious matters  
25 would be immediately looked at by an intake  
26 investigator.

27 Other matters are assessed and  
28 then assigned to an intake investigator who has  
29 a case load and is continually triaging that  
30 case load, so does an initial assessment and  
31 then determines which matters require more  
32 urgent attention.

1 Q. And can you give the  
2 Commissioner some sense of the range of time  
3 that it typically takes the College between  
4 receiving a report and deciding on the  
5 appropriate regulatory response?

6 A. So if it is a matter of high  
7 risk, it could be -- as in this case, it could  
8 be 24 hours or a couple of days.

9 Q. When you say "as in this  
10 case," you mean when it was eventually made  
11 known to the College that Ms. Wettlaufer had  
12 confessed to crimes?

13 A. That's correct, that's  
14 correct. And so that would be similar with a  
15 matter of sexual abuse. Depending on the  
16 availability of verifiable information, that  
17 assessment moves very quickly.

18 And for other matters in intake  
19 that may be low to moderate risk -- again,  
20 depending on what's comes in -- it may take  
21 longer. I would say on average that those  
22 matters move through the intake process within  
23 six months. There are outliers, and there are  
24 outliers because of the volumes.

25 Q. But I take it from what you  
26 were telling Commission Counsel yesterday  
27 that the College is trying to continually staff  
28 to take account of the increase in volumes?

29 A. Yes, we are, and also looking  
30 at other mechanisms to appropriately respond  
31 because all of the things reported are not of  
32 the same magnitude, and we are looking at other

1 way -- other appropriate regulatory responses  
2 that may assist in moving things more quickly.

3 Q. Now, the other thing I think  
4 would be helpful for us all to clarify is in  
5 your evidence and in your affidavit, you  
6 distinction between two different kinds of  
7 investigations: The intake investigation,  
8 which of course is the one that was done by  
9 Ms. Yee in this case and that you reviewed, and  
10 what Commission Counsel and you have from time  
11 to time described as a "formal  
12 investigation" --

13 A. Yes.

14 Q. -- but at other times as a  
15 "Section 75 investigation." So I just want to  
16 make sure our nomenclature is consistent. Are  
17 you using "formal investigation" and a  
18 "Section 75 investigation" interchangeably?

19 A. Yes, I am.

20 Q. All right. And can you tell  
21 those who may not know enough about how the  
22 RHPA works what the difference is between the  
23 investigation that is done that is not  
24 authorized under Section 75 and those that are  
25 formal appointments of investigators under  
26 Section 75 of the RHPA -- or of the Code,  
27 actually?

28 A. So the first test for a  
29 formal Section 75 is that we have to meet the  
30 statutory requirement for a Section 75, and my  
31 understanding -- and again, everyone knows that  
32 I'm not a lawyer -- that is because it is a

1 very intensive and invasive process.

2 So a Section 75 means that an  
3 investigator has the full powers of  
4 investigation including being able to summons;  
5 being able to enter a workplace and retrieve  
6 documents; potentially enter a member's home  
7 and retrieve a computer or documents; to  
8 require witnesses to give evidence; to retrieve  
9 health records. There are very significant  
10 powers that go with an investigation.

11 It also is a very -- the College  
12 investigators have very deliberate processes to  
13 ensure that they are following the principles  
14 of administrative fairness, and it is a  
15 detailed, time-intensive process.

16 Q. And just, Commissioner, for  
17 your reference, the powers of the investigator  
18 under a Section 75 appointment are set out in  
19 Section 76(1) of the legislation you'll find at  
20 tab 2 of your legislative binder on page 1916.

21 And interestingly, the way it's  
22 actually described and might not be known to  
23 everybody in the room is that the investigator  
24 gets the same powers as are granted to a  
25 Commissioner under Section 33 of the  
26 Public Inquiries Act. So it does indeed  
27 provide investigators with, as Ms. Coghlan has  
28 very fairly described, the ability to actually  
29 summons witnesses and have them testify under  
30 oath.

31 And from time to time, indeed,  
32 is that something that the College has resorted

1 to in the context of a Section 75  
2 investigation, to your knowledge?

3 A. Yes, yes.

4 Q. Okay. And again, just to  
5 give those who haven't had the opportunity you  
6 have to work with these processes, Ms. Coghlan,  
7 a sense, when you're at the ICRC, and there's a  
8 full Section 75 investigation of something that  
9 the College has done, how many hundreds of  
10 pages are those reports?

11 A. I can't tell you the  
12 hundreds, but I can tell you the size of the  
13 stack --

14 Q. Yes.

15 A. -- and they are huge volumes.  
16 ICRC panel members spend hours and sometimes up  
17 to two days reviewing the packages for their  
18 monthly meeting. They take it very seriously,  
19 and the investigative report is very thorough.  
20 It will include, obviously, interview  
21 summaries, witness statements; it will include  
22 copies of medication administration records,  
23 patient documentation files. They are very  
24 extensive documents.

25 Q. Yes. Fair to say that in  
26 lots of College cases that you and I have  
27 looked at over the year, there's the full  
28 clinical record of every patient who is the  
29 subject matter of the investigation together  
30 with reports and interview summaries with all  
31 of the caregivers who were in any way related  
32 to that incident and so on?



1 A. That's correct.

2 Q. All right. Okay, that's  
3 helpful context for us to go back and talk  
4 about mandatory reports and termination  
5 reports.

6 So I think the question that the  
7 Commissioner is surely asking herself or many  
8 others here maybe is how much information does  
9 the College want to receive from employers  
10 together with the termination report? And let  
11 me ask a specific question first, and then by  
12 all means, amplify.

13 Does the College want the  
14 member's entire personnel file? Is that what  
15 the College -- would assist the College in  
16 conducting intake investigations?

17 A. No, it would not assist the  
18 College.

19 Q. Okay. And why is that,  
20 Ms. Coghlan?

21 A. We are counting on and need  
22 to be able to rely on the individuals who are  
23 closest to the incidents to identify  
24 information that will assist the College in  
25 assessing the risk that the nurse's practice  
26 poses, and receiving information that does not  
27 assist will bog down our processes.

28 Q. And what would one often see  
29 in personnel files, for example, that would  
30 "bog down," to use your language, your process?

31 A. It could be attendance  
32 records, it could be labour relations issues,

1 things like interpersonal conflict, conflicts  
2 over work schedules.

3 Q. So what is --

4 A. Attendance.

5 Q. What is it, then, that  
6 employers should provide to the College  
7 together with their termination report? What  
8 is the information that the College is looking  
9 for?

10 A. The College is looking for  
11 the employer's concerns that relate to their  
12 obligation for a mandatory report, and that  
13 obligation is in relation to concerns about  
14 competence, misconduct, or incapacity.

15 Q. Okay. And the report form  
16 identifies a contact individual. And what kind  
17 of information or knowledge does the  
18 College expect that contact individual to have?

19 A. We expect that the contact  
20 individual is the individual who's best  
21 informed about the incidents that have been  
22 reported to the College and can assist the  
23 College investigator in providing any  
24 additional information in relation to the  
25 nurse's practice that would assist in assessing  
26 any concerns about risk of harm to clients or  
27 residents.

28 Q. And should that person in  
29 the best case scenario and best practice be  
30 involved in preparing the report?

31 A. I would expect that that  
32 would be the person who was most knowledgeable,

1 yes.

2 Q. And so one of the other  
3 things that's come up in this Inquiry is  
4 witnesses have suggested that maybe there  
5 should be some changes to the College's intake  
6 process, and I know, Ms. Coghlan, that you're  
7 the first one to say that you're open to all  
8 helpful suggestions.

9 So what about this one: One was  
10 that the College provide a copy of the intake  
11 investigator's notes to the person that they  
12 are interviewing by phone and, you know, to  
13 ensure the accuracy of them is the notion. And  
14 what is your view of that, Ms. Coghlan?

15 A. Well, I've described the  
16 process so far, and I don't support that that  
17 would enhance the process in any way, and in  
18 fact, it would add a step that would further  
19 delay and draw out the -- not only the  
20 assessment of that individual matter but  
21 interfere with the movement of all cases  
22 through our process.

23 We have had no indication that  
24 there are problems with the ability of  
25 investigators to accurately record the  
26 information that they receive through an  
27 interview. And we count on employers who, in  
28 many cases, are members of the College  
29 themselves to provide complete and accurate  
30 information.

31 As well, investigators are very  
32 sophisticated in terms of their interview

1 skills, and it's my understanding that they are  
2 very good at clarifying, at checking, that they  
3 have captured, summarizing that they have  
4 captured things accurately and may at times  
5 read back to an individual to make sure that  
6 they've captured it in an accurate way.

7 Q. Okay, that's helpful. And  
8 what about the practice that is more often used  
9 than not, although not invariably, of  
10 conducting these interviews by telephone as  
11 opposed to actually going to the workplace of  
12 various employers and conducting an in-person  
13 interview? What thought has the College given  
14 to that choice that in most cases it's done  
15 with telephone interviews?

16 A. Again, this is an initial  
17 assessment and triage, and I can't imagine that  
18 there would be any additional advantage to a  
19 face-to-face interview. In fact, again, I  
20 suspect it would delay things. It certainly  
21 would draw out the College's processes, but I  
22 can't imagine that that would be of assistance  
23 to busy employers either who we sometimes have  
24 enough of a challenge scheduling a telephone  
25 interview.

26 Q. All right. I want to talk  
27 about some of the evidence that this Inquiry  
28 has heard that relate to some of the  
29 Commissioner's questions yesterday about sort  
30 of how the College might have looked at certain  
31 kinds of information that it didn't have, and  
32 that's not a criticism, but just what its risk

1 assessment would be or what its view of the  
2 reporting obligations of employers would be  
3 based on some of the information that we now  
4 have and the evidence we now have from the  
5 Inquiry.

6 And so let me take you to the  
7 scenario that we know something about arising  
8 at Meadow Park. We know that Ms. Wettlaufer  
9 resigned in 2014, her employment at Meadow  
10 Park, and that from the evidence at this  
11 Inquiry that at time she resigned, she  
12 acknowledged that she had an alcohol and drug  
13 addiction; she had overdosed the weekend  
14 following --

15 MS. CORRENTE: I'm going to  
16 object because that's not an  
17 accurate characterization of the  
18 evidence. If you will recall,  
19 there was a resignation letter  
20 submitted on September the 25th  
21 of 2014, and at that time,  
22 Ms. Wettlaufer indicated that  
23 she had an illness for which she  
24 required treatment; however, at  
25 that time, she had not indicated  
26 that she had any substance abuse  
27 issue. That information came  
28 later, days later. So I just  
29 wanted to clarify that point.

30 BY MS. ROTHSTEIN:

31 Q. That's a fair point, and that  
32 bespeaks my lack of precise knowledge of the

1 evidence, and I'm grateful to my friend. So  
2 let me rephrase it. I don't mean in any way to  
3 misstate the evidence. For the purpose of my  
4 question, whatever the evidence is is the way  
5 it should be put to Ms. Coghlan.

6 So what we know is that the  
7 employer receives a letter of resignation and  
8 later learns that, within days, Ms. Wettlaufer  
9 had an alcohol and drug addiction that had  
10 re-emerged and, indeed, that she'd overdosed  
11 over the weekend following her resignation and  
12 that she advised Meadow Park that she would be  
13 seeking treatment and that she herself viewed  
14 herself as no longer able to work as an RN.

15 And finally, we know that there  
16 was some evidence that narcotics were missing.  
17 Ms. Wettlaufer was suspected, but the employer  
18 wasn't able nor were police, to be able to  
19 squarely link those missing narcotics to her.

20 MS. CORRENTE: Sorry, and I  
21 don't mean to object. I just  
22 want to clarify one point. My  
23 recollection of the evidence was  
24 that she had talked about  
25 overdosing and potentially a  
26 substance abuse issue, but I  
27 don't recall ever any mention of  
28 alcoholism, just to clarify that  
29 point.

30 MS. ROTHSTEIN: Okay.

31 MS. CORRENTE: Not in relation  
32 to the information she provided

1 to Meadow Park.

2 MS. ROTHSTEIN: Okay.

3 THE COMMISSIONER: Thank you.

4 BY MS. ROTHSTEIN:

5 Q. So take counsel's refinement  
6 of my scenario, if you would. In those  
7 circumstances, would you have expected an  
8 employer to report Ms. Wettlaufer to the  
9 College?

10 A. Yes.

11 Q. And why is that?

12 A. Because the employer has  
13 information about a nurse who poses a risk to  
14 the College, and it fits within the legislated  
15 definition of a mandatory report, and the  
16 legislated definition requires reports where  
17 there's knowledge of incapacity.

18 Q. And you're referring,  
19 Ms. Coghlan, to Section 85.52 of the Code?

20 A. That's correct.

21 MS. ROTHSTEIN: All right. And  
22 Commissioner, again, for you,  
23 tab 2 of your binder, page 1924.

24 THE COMMISSIONER: Thank you.

25 BY MS. ROTHSTEIN:

26 Q. And I'm not going to read it  
27 out loud; it is difficult legislative language.  
28 But I take it that what you're saying is,  
29 Ms. Coghlan, as you understand the legislative  
30 regime, where there is a resignation and the  
31 employer learns that that resignation is  
32 related to incapacity or may be related to

1       incapacity, the mandatory reporting obligation  
2       is triggered?

3                       A. That's my understanding from  
4       the legislation.

5                       Q. All right, okay. But in  
6       light of that, let's take a look, if we may, at  
7       the College's mandatory reporting guide to  
8       employers, and I'd ask you to turn up your  
9       affidavit and to tab O. And the employer  
10      description of obligations begins, and we're at  
11      Document 60147, page 4.

12                      MS. CORRENTE: Sorry. And  
13                      again, I'm always reluctant to  
14                      interrupt but to the extent  
15                      these questions are being posed  
16                      to the witness in relation to  
17                      reporting by Meadow Park, I  
18                      would suggest that we use the  
19                      version of the guide which was  
20                      in force at the time.

21                      MS. ROTHSTEIN: It's the same on  
22                      this language. It's identical.

23                      MS. CORRENTE: Okay. I just --

24                      MS. ROTHSTEIN: It's identical.

25                      MR. VAN KRALINGEN: Sorry, if  
26                      you want that version, I've got  
27                      it here.

28                      MS. ROTHSTEIN: I've got it too.

29                      MS. CORRENTE: It's the next  
30                      one.

31                      MS. ROTHSTEIN: It's the next  
32                      one.



1 MS. CORRENTE: Sorry about that.

2 MS. ROTHSTEIN: It's the  
3 previous tab. We can do either  
4 one, but the language is the  
5 same. I've checked them, and  
6 there's only one paragraph  
7 that's different, and it's not  
8 this one.

9 THE COMMISSIONER: All right.  
10 But if we refer --

11 MS. ROTHSTEIN: But we'll go to  
12 it.

13 THE COMMISSIONER: Yes.

14 MS. ROTHSTEIN: Yes.

15 THE COMMISSIONER: So tab N,  
16 then, is it?

17 MS. ROTHSTEIN: Yes.

18 THE COMMISSIONER: All right.  
19 Thank you.

20 BY MS. ROTHSTEIN:

21 Q. So we're, again, also at  
22 page 4, also under Section 2, "Employers." So  
23 the first paragraph deals with the obligation  
24 to report in relation to termination. It's  
25 really the third paragraph at the bottom of  
26 that page: "An employer must also" --

27 THE COMMISSIONER: Can you just  
28 wait till it gets on the screen?

29 MS. ROTHSTEIN: Oh, so sorry.  
30 Thank you. So sorry.

31 THE COMMISSIONER: Thank you.

32 BY MS. ROTHSTEIN:

1 Q. So we're going to go down, a  
2 little further down on that page, if we may,  
3 please. Thank you. There we go:

4 "An employer must also file a  
5 report if he or she intended to  
6 terminate the nurse's employment  
7 but the nurse resigned first."

8 And then it goes on:

9 "When, following a grievance, an  
10 employer accepts a resignation  
11 in lieu of termination, or makes  
12 another agreement with the  
13 nurse, the employer continues to  
14 have a legal obligation to  
15 report to the College."

16 So stopping there for a moment,  
17 Ms. Coghlan, I take it that the statement that  
18 is set out there is true?

19 A. Yes, it is.

20 Q. But it doesn't encapsulate  
21 the situation that you and I just discussed?

22 A. That's correct.

23 Q. Right. And in light of that,  
24 do you agree that this guide should be given,  
25 perhaps, a redraft to better encapsulate some  
26 of the language of the legislation?

27 A. Yes. We have looked very  
28 carefully at the guide several times and are  
29 doing it again. And one of the things that I  
30 observed following the discussion -- the  
31 discussions that have taken place at the  
32 Inquiry is that we need to be very clear that

1 this guide is not legal advice and to ensure  
2 that employers are alert to their obligation to  
3 understand the legislation and to follow it.

4 So the College has attempted in  
5 all of our documents to use clear language and  
6 not what we call "legalese," and I think what  
7 is a fair observation here is that it may be  
8 perceived as the information being incomplete,  
9 and we will definitely attend to that.

10 MS. ROTHSTEIN: So,  
11 Commissioner, I was going to  
12 move on to a new subject matter.  
13 Might this be the appropriate  
14 time for a break?

15 THE COMMISSIONER: Yes. Can I  
16 just get a sense of how long you  
17 anticipate being in --

18 MS. ROTHSTEIN: Maybe ten more  
19 minutes.

20 THE COMMISSIONER: Then unless  
21 you --

22 MS. ROTHSTEIN: You want me to  
23 keep going?

24 THE COMMISSIONER: I think you  
25 should go ahead and finish.

26 BY MS. ROTHSTEIN:

27 Q. All right. So the next area  
28 that I wanted to talk to you about,  
29 Ms. Coghlan, is in relation to some of the  
30 information that has been put into evidence  
31 about the history of Ms. Wettlaufer with her  
32 colleagues and at Caressant that wasn't known

1 to the College at the time that you did your  
2 assessment, and I want to get your views on  
3 what kind of risk assessment, how your risk  
4 assessment would apply if that kind of  
5 information had come forward.

6 So you've had a look at the  
7 document brief which is in front of you,  
8 Commissioner, and compromises all documents  
9 that are in the evidence already.

10 And in order to prepare yourself  
11 for giving evidence, Ms. Coghlan, you have gone  
12 through all of those documents -- all counsel  
13 in the room know that -- and to the extent that  
14 you can, you're able to assist them with  
15 answers to questions about them?

16 A. Yes, I am.

17 Q. All right. But to be clear,  
18 none of these documents except for the ones  
19 dealing with, at the beginning, the exercises  
20 that the College did at Caressant itself in  
21 terms of providing information at their  
22 request, but from tabs -- basically from tabs 3  
23 on, you weren't aware of any of those documents  
24 in relation to Bethe Wettlaufer; is that fair?

25 A. That's correct.

26 Q. All right. So with respect  
27 to the incidents that are described in these  
28 documents that weren't reported to the College,  
29 what would you have expected an intake  
30 investigator to consider, take into account,  
31 assess? Which --

32 Let me start again. What would

1 you have expected of an intake investigator in  
2 terms of their risk assessment in relation to  
3 some of these incidents? What would have been  
4 the risks that would have been higher? What  
5 are the incidents that would have created a  
6 lower risk?

7 A. With the risks that weren't  
8 reported?

9 Q. Correct.

10 A. Yes. Well, when I have a  
11 look at it and I anticipate that an intake  
12 investigator would have a similar observation  
13 is that there are a number of incidents that  
14 are of serious concern as they fall into the  
15 category of abuse.

16 So, for example, proceeding with  
17 disimpaction when a client is screaming out in  
18 pain is clearly an abusive behaviour. Telling  
19 a colleague, don't worry about that call bell,  
20 I'll -- a patient needing pain medication, I  
21 believe was the example, we'll wait and see if  
22 she rings again.

23 MS. JONES: Commissioner,  
24 Mr. Golden has risen.

25 MR. GOLDEN: I understand that  
26 there is a whole body of  
27 documents that this witness did  
28 not see and that the College did  
29 not see. But in fairness to  
30 those of us who were here and  
31 had probably an hour solid of  
32 evidence, just about that issue

1 of the disimpaction including  
2 from nurses who were involved  
3 who were providing treatment,  
4 who had their opinions about it,  
5 for this witness to say without  
6 that context, without having  
7 reviewed the transcripts and  
8 understanding what the  
9 professionals who were involved  
10 said about it -- which was clear  
11 that the disimpaction should  
12 continue -- an assumption has  
13 been made that a resident  
14 screaming out and that's clearly  
15 wrong and the College should  
16 have been told -- well, had  
17 the College asked, what they  
18 probably would have been told  
19 was the whole context.

20 MS. ROTHSTEIN: So,  
21 Commissioner, if I just may, I  
22 am not asking this witness  
23 whether the College should have  
24 been told or not. I'm not going  
25 there with this witness.

26 What I'm trying to get out from  
27 this witness which I think will  
28 be of assistance to you in this  
29 systemic Inquiry is more  
30 important.

31 It's not whether these have  
32 actually been substantiated. We

1 all know that you're going to  
2 have to make some findings about  
3 that, and this witness isn't in  
4 a position to provide us with  
5 any assistance as to whether the  
6 underlying events have been  
7 substantiated either in a way  
8 that shows that Ms. Wettlaufer  
9 was engaged in abuse or not.  
10 It's to give you a picture and  
11 to give everyone here a picture  
12 of how the College based on  
13 information received looks at  
14 these incidents and where  
15 various kinds of things, if  
16 substantiated, fit on the range  
17 of risk.  
18 That's the purpose of this  
19 evidence. I think it is  
20 helpful. I think this witness  
21 is in a position to do it. But  
22 I'm certainly not suggesting  
23 that she or I know all the  
24 nuances of it. So it's being  
25 put for the purpose of  
26 illustration and example and a  
27 way of giving you some better  
28 understanding of how that risk  
29 assessment is done in relation  
30 to particular reported events.  
31 THE COMMISSIONER: I think what  
32 is helpful from this and would

1 be -- and this is what I  
2 understand the intent of the  
3 question is: If the College had  
4 asked Caressant Care when it  
5 filed its report of termination,  
6 if it had asked and taken the  
7 file and reviewed the file and  
8 reviewed all the incident  
9 reports in it, are there  
10 incident reports in there that  
11 would have caused them concern?

12 MS. ROTHSTEIN: Yes, sure.

13 THE COMMISSIONER: And I don't  
14 have a problem with that  
15 question being answered, and  
16 perhaps they can just be given  
17 examples without, in any way,  
18 suggesting that there was a full  
19 contextual analysis of it but  
20 just indication. I would find  
21 that helpful.

22 Is that a problem, Mr. Golden?

23 MR. GOLDEN: No, that's fine.

24 THE COMMISSIONER: All right,  
25 thank you.

26 MS. ROTHSTEIN: We can go at it  
27 that way, Ms. Coghlan. So I can  
28 take her through some particular  
29 examples, if you like. So we  
30 could turn up tab 25.

31 THE COMMISSIONER: Actually, if  
32 she's prepared -- I heard her --



1 MS. ROTHSTEIN: Yes, she is  
2 prepared.  
3 THE COMMISSIONER: Prepared. So  
4 the question is -- you've heard  
5 what I said, and that is had you  
6 seen the full file, were there  
7 matters, incidents in the file  
8 that would have caused the  
9 College to have concern?  
10 THE WITNESS: Yes. And so I've  
11 given some --  
12 BY MS. ROTHSTEIN:  
13 Q. So let's just go back to the  
14 beginning, then, Ms. Coghlan. You were talking  
15 about a disimpacted bowel. You were saying  
16 that if it were substantiated that someone was  
17 in pain and she continued, that would be, you  
18 described, as abuse?  
19 A. Suspected abuse.  
20 Q. Suspected abuse.  
21 A. Yeah. Confirmed and  
22 assessed, absolutely. There was an incident  
23 that I recall where Ms. Wettlaufer made a  
24 comment, a patient requesting pain medication,  
25 don't bother, just leave it, and see if she  
26 rings again. There was --  
27 Q. Well, let's stop with that.  
28 What's the concern in relation to that incident  
29 if substantiated?  
30 A. Significant expectation of  
31 clients and nursing intervention is pain  
32 management and to leave a patient suffering

1 when there is a way to address that is abusive.  
2 It's neglect.

3 Q. Okay. Next incident that you  
4 recall?

5 A. There was a recall -- I  
6 recall a comment that -- derogatory comments  
7 about a client, something about him being an  
8 ignorant old man, a comment about a client  
9 asking for sex and her commenting that, tell  
10 him it'll be \$200.

11 THE COMMISSIONER: Actually, I  
12 am somewhat concerned about this  
13 because some of this was not in  
14 evidence, and it's certainly not  
15 contextual. What I understood,  
16 and --

17 MS. ROTHSTEIN: It's actually in  
18 the documentation that is in the  
19 evidence, Commissioner.

20 THE COMMISSIONER: I --

21 MS. ROTHSTEIN: But it wasn't  
22 probed, I suppose. So it's in  
23 the reports that were maintained  
24 by Caressant.

25 THE COMMISSIONER: I don't  
26 believe that, that last example,  
27 for example --

28 MS. ROTHSTEIN: I can find it.

29 THE COMMISSIONER: -- was  
30 actually in -- I don't say it  
31 isn't in the reports. Try not  
32 to interrupt me --

1 MS. ROTHSTEIN: Apologies,  
2 Commissioner.  
3 THE COMMISSIONER: -- while I'm  
4 speaking, Ms. Rothstein. I  
5 don't believe that it was  
6 explored in evidence here, and  
7 the problem is that, as we all  
8 know in this room, it's not just  
9 lawyers watching this; it's the  
10 public.  
11 So the suggestion may come  
12 across that that in some way  
13 actually took place, and we have  
14 no context for it.  
15 What I was hoping for is the  
16 type of information that is now  
17 coming out where we have  
18 complaints about pain medication  
19 not being given, possible  
20 incidents of a procedure going  
21 on despite it being painful,  
22 those kind of things, that's the  
23 essence of what I see of value  
24 in this.  
25 And if we stay away from  
26 specifics which haven't been  
27 proven or accepted or may be  
28 disputed, I think it would be  
29 just safer. Is there any  
30 problem in proceeding in that  
31 way?  
32 MS. ROTHSTEIN: I would just

1                   argue, Commissioner, that the  
2                   purpose is to give you the  
3                   biggest picture you can have  
4                   about what it was that Caressant  
5                   had documented in its own files  
6                   about this nurse and the extent  
7                   to which, if that had found its  
8                   way to the College, the College  
9                   would have viewed it.  
10                  And, in my view, the fact that  
11                  it hasn't been explored in  
12                  evidence is a reason for you to  
13                  stop and say to yourself, then I  
14                  can't make a finding that that  
15                  actually occurred but I can  
16                  nevertheless use this, this  
17                  assessment from the College to  
18                  inform my view of how this very  
19                  complex issue of risk assessment  
20                  is done by those at the College  
21                  and assess whether they do it  
22                  well or they don't, and the  
23                  fuller range you have of  
24                  different kinds of incidents and  
25                  how those factor into the  
26                  College's analysis, in my view,  
27                  you'll have a more informed  
28                  picture upon which to judge  
29                  because one of the things --  
30                  THE COMMISSIONER: Thank you,  
31                  but --  
32                  MS. ROTHSTEIN: Okay.

1 THE COMMISSIONER: -- we had the  
2 evidence from the Facilities on  
3 the incidents, and the College  
4 was here, and the College was  
5 able to examine on it.  
6 So what I would find useful in  
7 this case -- there is a gap  
8 here; there's no question in my  
9 mind. There's a statement in  
10 the report from Caressant Care  
11 saying -- and we have a whole  
12 bunch of other incidents in a  
13 file.  
14 I've now heard the College's  
15 explanation for why they did not  
16 probe behind it. I now  
17 understand what you are  
18 suggesting is that had the  
19 College looked behind it at the  
20 incident reports, there were  
21 reports there that would have  
22 changed, perhaps, their  
23 assessment.  
24 From an Inquiry point of view,  
25 that I think is what is relevant  
26 and helpful because it has  
27 implications possibly for the  
28 way in which employers are  
29 directed to complete forms,  
30 language, communication, and so  
31 on.  
32 But an exploration of the issues

1 of the incidents themselves,  
2 it's not, in my view, at this  
3 stage, appropriate. She didn't  
4 investigate them, the College  
5 didn't investigate them, and we  
6 finished the Facilities'  
7 evidence.

8 MS. ROTHSTEIN: Okay,  
9 Commissioner, I have to live  
10 with your ruling if that's what  
11 it is, but there are some other  
12 examples that she has that she  
13 noted.

14 THE COMMISSIONER: And that  
15 would be helpful. Here are the  
16 kinds of things that I have so  
17 far heard that are important:  
18 If there are practices which are  
19 leading to residents being in  
20 pain, those are the kind of  
21 things that should be drawn to  
22 the College's attention; issues  
23 relating to insufficient pain  
24 management or poor responses to  
25 it is important; those things  
26 may amount to abuse or neglect.  
27 But it doesn't matter what the  
28 label is. What I hear from you  
29 is those are the kind of  
30 incidents that you hope  
31 employers will report to you.  
32 Derogatory comments, similarly,

1                   either to a resident or even to  
2                   a staff member are the kinds of  
3                   information that you rely on  
4                   from the Facilities and the  
5                   employers. If there are other  
6                   examples, I would like to hear  
7                   them.

8                   MS. ROTHSTEIN: I understand,  
9                   Commissioner, that one of the  
10                  other --

11                 THE COMMISSIONER: Sorry,  
12                 Mr. Golden?

13                 MR. GOLDEN: Just so that we're  
14                 clear, there's a context to  
15                 these questions, and that's  
16                 allegations or suggestions that  
17                 the termination report from  
18                 Caressant Care was deficient  
19                 because the College is  
20                 suggesting it could have or  
21                 should have had other references  
22                 as well.

23                 But just so that we're clear, in  
24                 the Facilities section, there  
25                 was never a suggestion in the  
26                 cross-examination from the  
27                 College that there was  
28                 independently an obligation to  
29                 report, for example, the  
30                 incident involving the  
31                 disimpaction.

32                 What we're talking about here is

1                   whether or not the termination  
2                   report should have had or could  
3                   have had additional incidents in  
4                   it for which Elizabeth  
5                   Wettlaufer was disciplined which  
6                   led up to her termination.

7                   THE COMMISSIONER: Okay. I'm  
8                   not sure I accept all of the --

9                   MS. ROTHSTEIN: Commissioner,  
10                  Mr. Sandler was here; I've read  
11                  his cross-examination. There  
12                  was extensive cross-examination  
13                  of the Caressant Care witnesses  
14                  on the basis that the report  
15                  that they made in the end was  
16                  misleading, and it was put to  
17                  them in various ways.

18                 THE COMMISSIONER: Okay, okay.  
19                 Well, I think we can just stop  
20                 here. There is no question that  
21                 Caressant Care thought that it  
22                 had prepared a report which  
23                 should have alerted the College  
24                 to not only the concerns it  
25                 outlined but the concerns and  
26                 incidents before it.

27                 And there's no question that  
28                 through cross-examination the  
29                 language that was used, there  
30                 was the clear implication that  
31                 it would not have triggered that  
32                 kind of investigation. I don't



1 think that we need to re-till  
2 that soil here.  
3 The question here is, from my  
4 perspective for the Inquiry  
5 purposes, had the College been  
6 given a fuller understanding of  
7 the offenses or another way to  
8 phrase this is had the College  
9 chosen to take steps to  
10 investigate the file more fully  
11 and had a fuller appreciation of  
12 the offense, that's the point of  
13 disparity between the two.  
14 The College's view is that the  
15 report didn't trigger it and  
16 neither did the phone call and  
17 the Facilities' view is that it  
18 should have. It doesn't --  
19 MS. ROTHSTEIN: I'm trying to  
20 make my questions agnostic on  
21 that point. I'm trying to  
22 simply ask if the information  
23 had come to the College's  
24 attention, whether it's the  
25 fault of the College or the  
26 fault of the employer, what  
27 would the reaction of the  
28 College have been?  
29 I'm trying to be agnostic, with  
30 respect. I hope that's clear.  
31 THE COMMISSIONER: I think the  
32 problem is, of course, because

1 as soon as we take it out of  
2 context, all of the discussion  
3 isn't there. But if we can do  
4 it in two steps, it would be  
5 helpful.  
6 Firstly, I still would like to  
7 have any other list of matters  
8 that Ms. Coghlan says would be  
9 matters that she wished that an  
10 employer would identify, flag,  
11 or in other way bring to the  
12 attention of the College. That  
13 is clearly something very  
14 relevant to our Inquiry.  
15 And after that, if you want to  
16 ask her what she might have done  
17 with it, I'm not sure. We'll go  
18 there because that was the  
19 second part of it.  
20 MS. ROTHSTEIN: Right. But  
21 might I -- just before I get the  
22 full list from her in general  
23 terms, which she'll be happy to  
24 give you -- go back to two  
25 incidents that I understand were  
26 the subject of testimony and are  
27 documented in the evidence  
28 before this Inquiry?  
29 One involves Ms. Wettlaufer,  
30 what I want to call "shaking her  
31 backside" in front of the  
32 resident's face, and one

1 involves the hematoma in which  
2 there was a nurse who testified  
3 about the punctured hematoma and  
4 the unsterile scissors.

5 THE COMMISSIONER: I would have  
6 to understand why that would be  
7 relevant for this witness.

8 MS. ROTHSTEIN: On the very  
9 point that -- I think that it'd  
10 be helpful to you to know --  
11 like, is butt shaking a joke?  
12 Is it something that the College  
13 treats lightly, seriously? How  
14 does Ms. Coghlan view that  
15 particular incident and why?

16 THE COMMISSIONER: But she  
17 didn't. I mean, that's all --

18 MS. ROTHSTEIN: No, no.  
19 Hypothetically, if that  
20 information had come to her  
21 because the College had asked  
22 for it or because Caressant  
23 had provided it, either of those  
24 two things, what would have been  
25 the seriousness of that  
26 particular conduct?

27 THE COMMISSIONER: Well, can we  
28 start with the list? I mean,  
29 can we start with just getting  
30 in general terms the list of  
31 types of concerns that the  
32 expectation of the College is an

1 employer should be reporting  
2 and, generically, why?  
3 I mean, I've heard her say if  
4 you refuse to respond in a  
5 meaningful way to a request for  
6 pain medication, that amount may  
7 be abuse or neglect.  
8 As for the exploring particular  
9 incidents through -- I would  
10 have to be persuaded, and I  
11 think we'll do this after lunch,  
12 that there's relevance to that  
13 because it's out of context.  
14 It's not in the Facilities'  
15 time, it's --

16 BY MS. ROTHSTEIN:

17 Q. Well, I thought initially  
18 when we launched I had persuaded you,  
19 Commissioner, that it has relevance and  
20 understanding so all of us know what on these  
21 facts about Bethe Wettlaufer should be raising  
22 concerns for employers and for the College so  
23 that we understand that.

24 But let me finish the question  
25 that you want me to ask. Can you assist us,  
26 Ms. Coghlan, in telling us sort of with some  
27 kind of list other than just saying, you know,  
28 professional misconduct which isn't really  
29 helpful to the Commissioner, what the sorts of  
30 things are that the employer should be  
31 reporting to the College and why?

32 THE COMMISSIONER: Based on the

1 file.  
2 MS. ROTHSTEIN: Oh, based on the  
3 file. Okay.  
4 THE COMMISSIONER: Yes, based on  
5 the file. Like, you've read it,  
6 you said. And which of these  
7 incidents in general terms do  
8 you say we as the College wish  
9 we would have heard them, and  
10 here's in general terms why?  
11 Don't assume that they exist,  
12 but they're reported incidents.  
13 THE WITNESS: So can I refer to  
14 the specific incidents --  
15 THE COMMISSIONER: Yes.  
16 THE WITNESS: -- or not?  
17 THE COMMISSIONER: Yes.  
18 BY MS. ROTHSTEIN:  
19 Q. Okay, good.  
20 A. So I'll start with the  
21 general and then give an example using the  
22 incident, if that's all right.  
23 So the College would expect to  
24 receive information that signals a pattern of  
25 abusive behaviour, whether that's verbal abuse  
26 or physical abuse or emotional abuse.  
27 And so in the file, I saw  
28 examples of that; for example, the physical, it  
29 could be characterized -- and again, we  
30 would -- these are signals that we would then  
31 need to look into, but the College would view  
32 the report of a registered nurse using

1 unsterile scissors, I believe that it was, or  
2 instrument to puncture a hematoma is an example  
3 of physical abuse, as is moving a client who  
4 the nurse herself assesses to potentially have  
5 a broken hip without assistance could  
6 potentially be abuse. Those are the kinds of  
7 things the College would expect to be reported.

8 Remarks or behaviour of a sexual  
9 nature, the College would absolutely expect to  
10 receive a report about. The Regulated Health  
11 Professions Act has been amended several times,  
12 and sexual abuse is something that ministers of  
13 health and society at large are taking very  
14 seriously, and the College supports the zero  
15 tolerance that has been given to that matter.

16 So examples of those kinds of  
17 behaviours -- and they include remarks of a  
18 sexual nature -- we would expect an employer to  
19 report. I'm not immediately recalling other  
20 examples in the incidents that were not  
21 reported.

22 THE COMMISSIONER: That's very  
23 helpful.

24 MS. ROTHSTEIN: Okay. Is that a  
25 good time, then, Commissioner,  
26 to take our break?

27 THE COMMISSIONER: It is a good  
28 time. I'm very reluctant to ask  
29 this question, so perhaps I'll  
30 ask you, counsel, if you're  
31 comfortable asking it: Is this  
32 kind of information made clear

1 to employers? Like, the --

2 BY MS. ROTHSTEIN:

3 Q. By all means, ask Ms. Coghlan  
4 that question. She will answer it for you.

5 Ms. Coghlan, the question is do  
6 you think employers know and understand the  
7 sorts of high risk indicators that the College  
8 is looking for in terms of nursing behaviour?

9 A. Yes, I do. We distribute our  
10 publication to all members of the College. And  
11 so members of the College, if they are in an  
12 employer role, would absolutely have that  
13 information. We also --

14 Q. So just stopping there for a  
15 moment. Members of the College in an employer  
16 role would normally mean a nurse manager or a  
17 director of nursing, someone in that capacity?

18 A. Absolutely.

19 Q. Because they're not only  
20 supervising and acting as sort of the employer  
21 in the workplace, they are also continuing to  
22 be members of the College of Nurses of Ontario?

23 A. That's correct.

24 Q. Right.

25 A. And we know that the College  
26 for many years has had a program that is known  
27 as "One is One Too Many," and it is widely used  
28 in employment facilities by nurse managers,  
29 nurse educators, facility operators, directors  
30 of nursing in the workplace to help educate and  
31 stamp out potential abuse. So that is a widely  
32 known resource that the College has.

1                   The changes to the legislation  
2                   have been very -- over the years, have been  
3                   very publicly communicated. They've involved  
4                   consultation, opportunity for feedback, and  
5                   that has involved employer groups. So I would  
6                   expect that there's a very wide awareness in  
7                   the health care sector generally about the  
8                   focus on abuse prevention.

9                   And whenever the College changes  
10                  standards, there's wide consultation that  
11                  includes employer consultation as well as  
12                  communication of changes in standards in  
13                  legislation.

14                  The College has a publication  
15                  which is known as "Quality Practice," and is it  
16                  a publication that is specifically directed at  
17                  employers and facility operators, and perhaps  
18                  the best resource that the College has is a  
19                  very extensive website that we know employers  
20                  frequently access for information and for  
21                  resources and tools.

22                  THE COMMISSIONER: Okay. Thank  
23                  you.

24                  MS. ROTHSTEIN: Thank you.  
25                  Thank you, Commissioner. What  
26                  time are we reconvening?

27                  THE COMMISSIONER: We have a one  
28                  hour and 15-minute break, so the  
29                  court clerk always announces the  
30                  time that we're back, I believe,  
31                  so that we all synchronize our  
32                  watches, but it's an hour and 15



1 minutes from now.  
2 -- RECESSED AT 1:21 P.M.  
3 -- RESUMED AT 2:38 P.M.  
4 THE COMMISSIONER: Whenever you  
5 are ready, Ms. Rothstein.  
6 MS. ROTHSTEIN: So just before I  
7 complete my questions of Ms.  
8 Coghlan, I apologize, Your  
9 Honour, I misspoke and misled  
10 you on a fact.  
11 Thank you to Ms. Corrente for  
12 pointing it out.  
13 So you'll recall that Ms.  
14 Coghlan gave evidence about the  
15 way the mandatory reporting  
16 regime worked in relation to a  
17 resignation tied to a concern  
18 about incapacity, and I took you  
19 to the section of the Health  
20 Professions Procedural Code.  
21 Unfortunately, the timing was  
22 off in relation to the Meadow  
23 Park facts.  
24 So that you know, the Meadow  
25 Park facts arise, of course, in  
26 late September 2014, and the  
27 change to the Code that I made  
28 reference to did not come into  
29 effect until August of 2016.  
30 So in terms of a mandatory  
31 reporting obligation, that was  
32 not in fact the law in relation

1 to that scenario at the time  
2 those events arose.

3 And again, I apologize,  
4 Commissioner --

5 THE COMMISSIONER: Thank you  
6 very much.

7 MS. ROTHSTEIN: -- for that  
8 misstatement.

9 THE COMMISSIONER: I appreciate  
10 that.

11 BY MS. ROTHSTEIN:

12 Q. Ms. Coghlan, so there was  
13 sort of a lot of discussion before the lunch  
14 break about the incidents that you reviewed  
15 that you were not aware of at the time that you  
16 did the risk assessment in relation to Ms.  
17 Wettlaufer arising from her employment at  
18 Caressant Care.

19 And I just want to make sure  
20 that you have had a full opportunity to answer  
21 the Commissioner's question, which was what, if  
22 any, concerns would you have had in relation to  
23 those incidents had you been aware of them at  
24 the time that you did your risk assessment?

25 A. So when I reviewed those  
26 incidents, the picture that I got of the member  
27 was very different than the picture that was  
28 portrayed in the incidents that were reported  
29 to the College.

30 In some of those other  
31 incidents, we see a pattern of a nurse who is  
32 not caring, who is not respectful of clients,

1 and who has disregard for the care and  
2 compassion that would be expected of any nurse  
3 providing care to residents and/or clients.  
4 And in some instances, if proven, the  
5 behaviours would be characterized as abuse.

6 The other concern that it raises  
7 is that it was inconsistent with the statement  
8 at the end of the report that the College did  
9 receive which indicated that there were other  
10 issues but that they have not resulted in  
11 discipline, and in fact, some of the incidents  
12 that I reviewed that had not been reported had  
13 indeed resulted in discipline.

14 Q. Thank you.

15 A. Excuse me.

16 Q. Anything else?

17 A. They paint a picture of an  
18 individual who is intentionally engaging in  
19 behaviour that is not consistent with the  
20 standards and not reflective of professional  
21 nursing practice.

22 Q. And if we can compare that  
23 then with some of the reports that you see, and  
24 now, I'm not now talking about Ms. Wettlaufer,  
25 but reports that you see in this role - and you  
26 see literally hundreds of them a year - in  
27 which there is a pattern of medication errors.

28 And can you give the  
29 Commissioner some insight into, first of all,  
30 to what extent in your experience medication  
31 errors are in fact committed by good nurses,  
32 caring nurses, to use your words, respectful

1 nurses? What is your experience in that  
2 regard?

3 A. That nurses do make mistakes,  
4 and excellent nurses make mistakes, that that  
5 is what the literature tells us as well about  
6 medication error. But nurses who are  
7 conscientious and reflective welcome their  
8 mistakes being pointed out; they acknowledge  
9 them; and they put steps in place to correct  
10 those mistakes.

11 The other key feature of an  
12 accountable nurse is that their first priority  
13 is the client or the resident or the patient,  
14 and upon identification of an error, the first  
15 action would be to make sure that the patient  
16 is safe and to take any action required to  
17 ensure that.

18 The incidents that I have  
19 reviewed that were not reported to the College  
20 don't give a sense of a nurse who is putting  
21 the safety and well-being of the client first  
22 and foremost and, in fact, suggest that her own  
23 needs are taking precedence at times.

24 Q. And then let's go back to the  
25 alternative route. One of the other regulatory  
26 actions that is open to the College when it  
27 gets a Mandatory Report of Termination, which  
28 is to appoint an investigator and to do the  
29 section 75 investigation that you have  
30 described in general terms for the Commissioner  
31 before lunch.

32 Having regard for those powers,

1 can you assist the Commissioner with respect to  
2 what the scope of those investigations are and  
3 whether they are by definition an investigation  
4 of the nurse's entire nursing history at that  
5 employer or whether in fact they are more  
6 limited in scope and, if so, why?

7 A. Yes, those investigations are  
8 focussed on the incidents that are reported to  
9 the College, so the allegations that form the  
10 approval of that section 75 must be laid out,  
11 and those are based on the information that the  
12 College has received in the report.

13 That information also through  
14 the process must be provided to the member who  
15 has an opportunity to respond to the concerns  
16 that have been raised.

17 So the investigation is focussed  
18 on the information that was contained in the  
19 report.

20 Q. And just so the Commissioner  
21 has the full picture, am I right, Ms. Coghlan,  
22 that at the College of Nurses of Ontario, more  
23 often than not the nurse who is responding to  
24 an investigation commenced under section 75  
25 will be represented by legal counsel?

26 A. That's correct.

27 Q. Okay. So I want to talk  
28 about another aspect of the process of triage  
29 and risk assessment that the College does, and  
30 you have made the case and we have heard you  
31 that the College endeavours to identify the  
32 risk and then come up with a proportionate

1 regulatory response.

2 So that is based on -- you have  
3 told us the principles that is based on. But  
4 to what extent has the College done any digging  
5 or done any kind -- made any kind of attempt to  
6 assess whether that is increasing, decreasing  
7 recidivism or having no impact?

8 A. Well, actually, what is  
9 interesting, we did have a look to see if there  
10 was anything in the literature about  
11 recidivism, and there isn't in respect to  
12 nursing regulatory intervention.

13 So our internal statistical  
14 experts conducted a recidivism review, and they  
15 went to the literature and defined the  
16 definition of "recidivism" and for the purpose  
17 of the study used a period of three years.

18 So that means for nurses who  
19 were reported and I believe it was between --  
20 reported from the time period 2006 until the  
21 end of 2014, they looked at all of the  
22 incidents of employer reports and then did an  
23 analysis to determine, of those reports, how  
24 many were the subject of a repeat report or  
25 complaint within three years of the original  
26 report.

27 MS. ROTHSTEIN: So just stopping  
28 you there and to assist the  
29 Commissioner, Commissioner, it  
30 is at tab 42 of the brief that  
31 was filed by Commission Counsel,  
32 but it is not yet in evidence.

1 And so I am going to ask -- I  
2 don't even have a document  
3 number for it, so I am in your  
4 hands, Commissioner, as to how  
5 best to mark this as an exhibit.  
6 Oh, thank you, so Commission  
7 Counsel has given me the doc ID,  
8 which is 72873, thank you.  
9 So might this marked as the next  
10 exhibit, Commissioner?

11 THE COMMISSIONER: So is it only  
12 three pages in length, this  
13 report?

14 THE WITNESS: Yes, it is.

15 MS. ROTHSTEIN: Yes.

16 THE COMMISSIONER: All right, so  
17 the document entitled  
18 "Recidivism of Nurses Subject to  
19 a Report From an Employer, May  
20 7, 2018", document 72873, will  
21 be the next exhibit, and that  
22 number, Madam Clerk, is?

23 THE COURT CLERK: 125.

24 THE COMMISSIONER: Exhibit 125.

25 EXHIBIT NO. 125: Document  
26 entitled "Recidivism of Nurses  
27 Subject to a Report From an  
28 Employer, May 7, 2018", Document  
29 No. 72873.

30 BY MS. ROTHSTEIN:

31 Q. Thank you, Commissioner.

32 And, Ms. Coghlan, have you got a

1 copy of it in front of you there?

2 A. I do.

3 Q. Okay. Sorry, I interrupted  
4 you, but I wanted to make sure that the  
5 Commissioner had it. So you were providing a  
6 summary of what these three pages did and what  
7 the findings were?

8 A. So the overall recidivism  
9 rate was 13.3 percent.

10 And then it was broken down to  
11 look at recidivism by outcome. So there are a  
12 variety of potential actions that the Registrar  
13 can take, and we looked then at recidivism by  
14 nature of the outcome of the first employer  
15 report; and for those, the vast majority of  
16 reports resulted in the remedial approach of  
17 what we call banked with notice and the  
18 recidivism rate was 12.4 percent, which is  
19 below the average for all reports from  
20 employers.

21 And we'll see in the document  
22 that the recidivism rate is slightly higher for  
23 members whose first matter resulted in an  
24 investigation for incapacity or professional  
25 misconduct, so that would be a section 57 or a  
26 section 75.

27 Q. And just so we can all  
28 understand some of the nomenclature, there is a  
29 couple here that are a little opaque.

30 And you have explained banked  
31 with notice, which is the one that you have  
32 just referred to, and I think everyone



1 understands now what an incapacity section 58  
2 is, which would be a formal incapacity process;  
3 am I right?

4 A. That's correct.

5 Q. And then we now know what an  
6 investigation under section 75 is.

7 There is "Meet with the Director  
8 of [...]" and is that Investigations and  
9 Hearings?

10 A. That's correct, professional  
11 conduct --

12 Q. All right, which is someone  
13 who reports to you and isn't, I assume in the  
14 scheme of things, quite as serious as meeting  
15 with you in terms of the scale of remedial  
16 response or the force of it, as you have put  
17 it; is that fair?

18 A. That's correct.

19 Q. And then there is meeting  
20 with you, and that is self-evident.

21 But the next one "Did Not Attend  
22 Meeting - Banked", and can you explain to the  
23 Commissioner what that connotes?

24 A. Yes, I will start with a  
25 minor explanation about the meeting with me.

26 So while the meeting with me is  
27 intended to be remedial, I have reserved my  
28 decision as to whether or not a section 75  
29 investigation is warranted. And the purpose of  
30 that meeting is to determine whether the nurse,  
31 having been required to review standards and  
32 reflect on the incidents and the application of

1 the standards to them, has sufficient insight  
2 to be able to provide assurances to the College  
3 with regard to his or her future practice.

4 So there are times when the  
5 outcome of that meeting may be a section 75.  
6 It is infrequent, but it does happen.

7 There are times when for a  
8 variety of reasons individuals may not attend  
9 the meeting, and I then have to make a  
10 determination about whether -- what the  
11 appropriate response is, because it is  
12 voluntary to attend a meeting.

13 And there are times when the  
14 determination is to bank the information with  
15 notice, so that is what that means and --

16 Q. But I take it there are times  
17 when you come to the conclusion that the  
18 reasons for not coming to meet with you raise  
19 further alarms?

20 A. Yes.

21 Q. And require a more serious  
22 response?

23 A. That's correct.

24 Q. Is that fair?

25 A. Yes, it is.

26 Q. Okay, thank you for that.

27 And then "Executive Resolution"  
28 refers to what?

29 A. So that was under the  
30 previous legislation. So we went through  
31 yesterday when the Complaints Committee regime  
32 and the Executive Committee, when the Executive

1 Committee had a role, a different role. So  
2 executive resolution was a similar approach to  
3 Executive Director action but it came -- it was  
4 used during the time when the legislative  
5 framework was different from what it is today.

6 So because this study looked at  
7 the period from 2006, there were changes in  
8 2009, I believe, and so executive resolutions  
9 were no longer used because the Executive  
10 Committee no longer fulfilled that role.

11 Q. It is now the ICRC?

12 A. It is the ICRC.

13 Q. Okay. All right, well, that  
14 is helpful, thank you, Ms. Coghlan.

15 So finally, the last subject for  
16 you touches on one of the very first things  
17 that you gave evidence about yesterday in  
18 response to the questions of Commission Counsel  
19 and that was the kinds of collaborations that  
20 the College is engaged in with the Ministry of  
21 Health and Long-Term Care and, indeed, with  
22 other stakeholders in the health care sector.

23 And you told us about the JPNC,  
24 which I believe stands for the Joint Provincial  
25 Nursing Committee, and you told us that that's  
26 a collaboration between the MOHLTC and the CNO,  
27 but I don't think that you gave us yet an  
28 example of the kinds of projects that that  
29 collaboration is working on.

30 And if I understand it  
31 correctly, one of the projects relates  
32 specifically to long-term care?

1                   A. Yes. So first of all, the  
2                   Joint Provincial Nursing Committee is made up  
3                   of all of the nursing stakeholders in the  
4                   system, so it includes the professional  
5                   associations, the union, educators, employer  
6                   group, and the Ministry of Health and Long-Term  
7                   Care as well as the Ministry of Training,  
8                   Colleges and Universities who are responsible  
9                   for nursing education. So it is a nursing  
10                  stakeholder group that provides policy advice  
11                  to the Ministry.

12                  And about 18 months ago, that  
13                  group determined that the priority that they  
14                  would focus on was issues in relation to  
15                  long-term care, so there has -- and the  
16                  College's role in that is providing support in  
17                  terms of how standards apply, providing some of  
18                  the data that we talked about yesterday in  
19                  terms of employment, nurses who are employed in  
20                  the long-term care sector, the nature of their  
21                  employment, and then other partners are  
22                  bringing their perspective.

23                  So for example, there will be  
24                  perspectives around the availability of nurses  
25                  to provide care in long-term care, the  
26                  remuneration of nurses in long-term care, the  
27                  supports that are in place, and the  
28                  implications for nursing education of changes  
29                  in the long-term care environment and the  
30                  needs, the changing needs of clients in the  
31                  long-term care environment.

32                  That is another huge piece of

1 the perspective of the needs in the long-term  
2 care system is that the needs of residents have  
3 changed enormously over the years, and it is  
4 not just providing an alternative place of  
5 residence for seniors in our society. These  
6 individuals often have very complex needs and  
7 their age range can be from very young to  
8 seniors.

9 So the complexity of the needs  
10 of individuals in the long-term care sector is  
11 another example.

12 So that this group will be  
13 providing recommendations to the Ministry that  
14 will inform policy direction.

15 Q. And then one other example of  
16 collaboration with the MOHLTC I understand is  
17 work that the College is doing specifically  
18 with the Inspections Branch; is that correct?

19 A. Yes, that has been a  
20 collaborative series of meetings that was  
21 established with a group of College staff and  
22 representatives from the Inspections Branch of  
23 the Ministry to look at the different  
24 perspectives of risk in the long-term care  
25 sector. So the College has a perspective  
26 through its processes of some of the risks that  
27 we see, as does the Inspections Branch, and the  
28 goal there is to collaborate to identify  
29 opportunities to address those risks.

30 Q. And as I understand it, some  
31 of the issues that have been identified as  
32 requiring that examination are documentation,

1 medication, abuse prevention and education; is  
2 that right?

3 A. That's correct.

4 MS. ROTHSTEIN: Okay. Well,  
5 thank you very much, Ms.  
6 Coghlan. You know that other  
7 counsel have questions for you.  
8 Thank you, Commissioner, those  
9 are my questions.

10 THE COMMISSIONER: Thank you  
11 very much, Ms. Rothstein.

12 MS. JONES: And, Commissioner,  
13 Mr. Van Kralingen on behalf of  
14 one of the family groups.

15 THE COMMISSIONER: Thank you,  
16 Ms. Jones.

17 MR. VAN KRALINGEN: Good  
18 afternoon, Commissioner.

19 THE COMMISSIONER: Good  
20 afternoon, Mr. Van Kralingen.

21 CROSS-EXAMINATION BY MR. VAN  
22 KRALINGEN:

23 Q. Good afternoon, Ms. Coghlan.

24 A. Good afternoon.

25 Q. Any name is Alex Van  
26 Kralingen, and I am one of the lawyers  
27 representing one of the family groups.

28 I have prepared a small  
29 collection of documents that is in a yellow  
30 cover sitting on the top there.

31 A. Thank you.

32 Q. And I wanted to apologize

1 first, because I think I might have misspelled  
2 your name, putting an "e" instead of an "a",  
3 so --

4 A. That's okay.

5 Q. -- as someone with a last  
6 name that gets misspelled wrong frequently, I  
7 am very sympathetic to that.

8 So I am going to ask you to keep  
9 both your affidavit and that collection of  
10 documents with you, as I am going to refer to  
11 both during the course of my examination today.

12 Before we start looking at any  
13 of the documents, though, I want to start by  
14 better understanding an answer you gave to Ms.  
15 Jones yesterday, and I want to talk about the  
16 interim period between when a College commences  
17 an investigation regarding competence or  
18 capacity and the point of resolution of that  
19 complaint or report.

20 In the interim period, a nurse  
21 may be working for a different employer, and I  
22 am wondering if you could clarify your  
23 evidence. During that interim period, does the  
24 College contact the new employer?

25 A. I want to just clarify that  
26 you are talking about the period where a formal  
27 investigation has been initiated?

28 Q. Yes.

29 A. The -- during that period,  
30 the investigator who has been assigned may  
31 contact a current employer to obtain  
32 information about the nurse's current practice.

1 But the fact of an investigation is protected  
2 under the section 36, so they wouldn't be  
3 contacting to say this nurse is under  
4 investigation. They would be making what we  
5 call a general inquiry into the practice of a  
6 particular nurse.

7 Q. And the purpose of that  
8 inquiry is what?

9 A. The purpose is to determine  
10 whether the current workplace has concerns that  
11 are similar to those that have been reported to  
12 the College.

13 Q. Okay, I am going to show you  
14 a document that Ms. Jones showed you yesterday.  
15 It is document 37176. This is the letter, and  
16 as it is getting pulled up, I'll just describe  
17 it. It is the November 2nd, 1995, letter from  
18 Ms. Pavletic at Geraldton Hospital regarding  
19 Ms. then Parker, now we know Wettlaufer, her  
20 termination.

21 And if you could just cycle down  
22 to the middle of the page, please, under the  
23 "Employment History" section, there is a  
24 reference to:

25 "Current Employment: Geraldton  
26 District Association for  
27 Community Living".

28 And my understanding is that  
29 that is a group home for those who are  
30 intellectually challenged.

31 I reviewed the database of  
32 documents for this Inquiry, and I can't find



1 any record of the College contacting the  
2 Geraldton District Association for Community  
3 Living in 1995 or any time thereafter. I'm  
4 wondering if you are aware if the College ever  
5 contacted this group home in connection with  
6 Ms. Wettlaufer's practice?

7 A. I am not aware. And my  
8 response to your earlier question was about our  
9 current practice, so I am not familiar with  
10 what the practice was in 1995.

11 Q. So that is actually helpful.  
12 It is very possible that in 1995 the College  
13 made no effort to contact the Geraldton  
14 District Association for Community Living  
15 during the interim period while the  
16 investigation was ongoing and before the  
17 resolution of the investigation?

18 A. That is possible.

19 Q. Okay. So jumping ahead to  
20 the point where Ms. Wettlaufer is terminated by  
21 Caressant Care Woodstock and starts working for  
22 Meadow Park, I assume Ms. Wettlaufer would have  
23 somehow informed the College that she had moved  
24 to a new employer. Is there an obligation to  
25 register if you have a new employer?

26 A. That was in --

27 Q. 2014.

28 A. Yes, there was, yes, it was  
29 her obligation to do that.

30 Q. An Intake Investigator,  
31 though, is not in any way authorized to call a  
32 current employer of a nurse for whom a report

1 has been made that is going through the intake  
2 process; is that fair to say?

3 A. Well, what I can -- I can't  
4 say in a blanket way that they are -- they are  
5 not obligated, but it may be part of their  
6 inquiry. It would depend on the nature of the  
7 incidents that were before them and whether  
8 they were aware of a change in employer.

9 So there are times when an  
10 Intake Investigator who has -- where the  
11 register shows that the individual has changed  
12 a practice setting will make that general  
13 inquiry that I spoke of.

14 Q. And that general -- sorry,  
15 and the Intake Investigator is authorized to  
16 make that general inquiry?

17 A. They can make any inquiry  
18 that they want, but there is no obligation on  
19 the facility to respond, and many facilities  
20 will not speak to a general inquiry. They will  
21 say that they are not able to make any comment.

22 Q. But the purpose of the  
23 inquiry doesn't change as between an Intake  
24 Investigator and a section 75 investigator?

25 A. No, it does. With a section  
26 75 investigation, the Intake Investigator  
27 can -- has the powers, if necessary, to compel  
28 someone to provide information.

29 Q. All right. If you could go  
30 to tab 17 of the yellow document book that I  
31 have got for you, and it is document 36834.  
32 This is the Reports Intake Assessment Form.

1 First of all, do you recognize this form of  
2 document?

3 A. Yes.

4 Q. And I assume this is a  
5 document that is frequently used at the College  
6 in connection with the intake process?

7 A. That's correct.

8 Q. This is the Intake Assessment  
9 Form in connection with the Wettlaufer report  
10 from Caressant Care. So you will see at the  
11 top the "Date Received" is May the 1st, and you  
12 will see on the right that there is a box that  
13 says the "Date Allocated" is July 23rd, 2014?

14 A. That's correct.

15 Q. You went through the report  
16 in some detail with Ms. Rothstein. On July 23,  
17 2014, the employer's report comes in which  
18 shows on its face multiple concerns leading to  
19 the termination of Ms. Wettlaufer's employment.  
20 Is this the sort of information which might  
21 prompt an Intake Investigator to call a current  
22 employer to ask questions about a nurse?

23 A. I wouldn't expect -- I don't  
24 know for sure. I wouldn't expect that it would  
25 be the kind of information that an investigator  
26 might inquire of another employer.

27 Q. There is no legal barrier to  
28 doing so?

29 A. There is no legal barrier,  
30 but again, it is a voluntary inquiry.

31 Q. I understand that.

32 A. And that is why I think

1 that -- that is what I am basing my response  
2 on, that I wouldn't expect that they would,  
3 because their experience nine times out of ten  
4 is that the employer will indicate that they  
5 are not able to assist.

6 Q. As you know, the Commissioner  
7 will be thinking about possible improvements to  
8 the system generally.

9 A. Yes.

10 Q. And I am wondering would an  
11 expectation for Intake Investigators to call  
12 current employers for a nurse who is subject to  
13 an intake process, do you think that that would  
14 be helpful?

15 A. I think what would be helpful  
16 is for there to be an expectation that  
17 employers would be forthcoming with information  
18 that may assist the College in the review of a  
19 matter.

20 Q. But the current employer may  
21 not know that there is a report about a former  
22 employer?

23 A. Right, where the Intake  
24 Investigator identifies that it would be  
25 helpful to have information from the current  
26 employer, it would be very helpful if the  
27 employer were able to provide that information.

28 Q. I understand. And my  
29 understanding from what you were telling me  
30 earlier in our time today is that many Intake  
31 Investigators do not contact the current  
32 employer; have I misunderstood that?

1                   A. I said that my expectation or  
2 my -- and maybe that is not the best word to  
3 use. I don't know for sure. I would have to  
4 ask them. But my understanding from  
5 conversations with investigators is that they  
6 may not, because they become familiar with the  
7 facilities that are helpful and those who will  
8 just simply say we are not able to provide  
9 comment and so that --

10                  Q. Do you think that would be  
11 a --

12                  A. -- is what I am basing my  
13 assumption on.

14                  Q. I didn't mean to speak over  
15 you. Did you think it would be a best practice  
16 or do you think it would be a best practice for  
17 Intake Investigators to call a current employer  
18 in circumstances where an intake has been  
19 received by the College?

20                  A. Where they can rely on the  
21 information, yes.

22                  Q. All right. I also wanted to  
23 talk a little bit about your conversation with  
24 Ms. Jones about the public registry and unpack  
25 some of the questions you were asked yesterday.

26                  As you may know, when Ms.  
27 Wettlaufer applied for a job at Caressant Care,  
28 she did not list her employment at Geraldton  
29 Hospital as part of her experience, and during  
30 my cross-examination of Ms. Crombez, she  
31 indicated it would have been helpful to know  
32 about Ms. Wettlaufer's employment at Geraldton.

1                   So my question to you is, to  
2                   your mind, is there any legal or practical  
3                   barrier to having a nurse's entire employment  
4                   history listed on the public register?

5                   A. I think it is more a  
6                   practical consideration. The reality is that  
7                   175,000 nurses are engaged in approximately  
8                   175,000 different employment positions with  
9                   13,000 different employers.

10                  And for the College, the  
11                  College's information needs to contain  
12                  information that is relevant to its regulatory  
13                  role in terms of the information that the  
14                  College has and can verify about the member.

15                  So that is why I think I have  
16                  said earlier in my testimony that all members  
17                  of the system need to be part of the safety  
18                  net, and employers need to have mechanisms in  
19                  place to obtain information from member -- from  
20                  future employees about their history and be  
21                  able to check reference checks.

22                  The other reality is that our --  
23                  we are relying on nurses to self-report, and  
24                  the College, if the College were to have to  
25                  verify every time -- and we do, we have to  
26                  verify any information that goes on our public  
27                  register, we have to verify that it is  
28                  accurate. So I think that that would be a  
29                  logistical -- a very onerous logistical issue.

30                  Q. My understanding is that your  
31                  Annual Membership Renewal Form expressly  
32                  requests that a nurse provide her employment

1 summary for the year; am I mistaken?

2 A. No, you are absolutely  
3 correct, and one of the changes that we are  
4 going to be implementing with our -- I think I  
5 also alluded to changes in our information  
6 system, and one of the changes will be to  
7 provide that, all of that information.

8 So if I report in 2017 that I  
9 currently have three employers, all three  
10 employers will appear on the public register.

11 Q. What I am asking, though, is  
12 I wonder is there a mechanism to aggregate the  
13 information at least on a going-forward basis  
14 to connect that in some way to the public  
15 register to create that history that I have  
16 suggested to you?

17 A. I'm not the expert in that,  
18 but I would be happy to take that  
19 recommendation back for consideration.

20 Q. Yeah, I am not the expert in  
21 that either, so...

22 If you turn to your affidavit,  
23 please, at page 34 and paragraph 83.

24 A. I'm sorry, which page,  
25 please?

26 Q. Page 34 and paragraph 83.

27 In this paragraph you discuss  
28 the triage function of an Intake Investigator,  
29 and I assume that there are instances which are  
30 more urgent for the College in connection with  
31 a particular report and less urgent?

32 A. That's correct.

1 Q. Instances which may require  
2 more immediate intervention than those, that  
3 although are important, are not necessarily  
4 urgent?

5 A. That's correct.

6 Q. The mandatory reporting guide  
7 contemplates that a report needs to be filed  
8 immediately if a nurse poses a continued risk?

9 A. That's correct.

10 Q. Could you explain to us what  
11 a "continued risk" means?

12 A. That means where the employer  
13 has concerns that the conduct or the behaviour  
14 or the actions of the nurse are likely to  
15 continue to be a risk to the public.

16 So for example, if -- a very  
17 serious example is sexual abuse. And if there  
18 is an allegation of sexual abuse, then there is  
19 the potential that clients are at continued  
20 risk with an individual who may be engaging in  
21 sexual abuse.

22 If there is deliberate  
23 intentional physical abuse, there may be a  
24 concern that other clients would be very  
25 vulnerable in the presence of that nurse.

26 Those are examples of a  
27 continued risk.

28 Q. And so earlier today you were  
29 talking with Ms. Rothstein about sort of how  
30 you manage the urgent issues like when they  
31 come up versus things that are less urgent, and  
32 I am wondering what was your process as of 2014



1 when a report would come in? How would you  
2 identify the things that you would put in the  
3 urgent pile versus the important but not urgent  
4 pile?

5 A. So those risk categories that  
6 we talked about earlier are used to assess the  
7 level of risk, and very generally, they fall  
8 into low, moderate and high risk. And the  
9 accumulation of risk factors move those things  
10 into high risk, so --

11 Q. I understand your answer, but  
12 what I am actually asking is at some point the  
13 document, the report, the employer's report  
14 lands in the College's office.

15 A. Yes.

16 Q. It looks, from Ms. Yee's  
17 intake report, that her first touch point with  
18 the file is July 23rd, even though it is  
19 received on May the 1st.

20 And what I am trying to  
21 understand is before July 23rd in 2014 --

22 A. Yes.

23 Q. -- was there anybody else at  
24 the College who would have done any kind of  
25 vetting of the report --

26 A. Thank you.

27 Q. -- and can you explain how  
28 that would have worked?

29 A. Yes, thank you very much.

30 So on receipt, so within 24  
31 hours, an Intake Associate reviews that matter,  
32 and anything that is identified as urgent, to

1 use your words, is reviewed by the Intake  
2 Coordinator or at that time it may have been  
3 the Manager, and there would be an initial  
4 assessment about the priority that should be  
5 given to that matter.

6 Q. And has that process changed  
7 in any way since Ms. Wettlaufer's crimes have  
8 come to light?

9 A. The only -- the only way that  
10 it has changed is that there -- rather than the  
11 Intake Coordinator doing this constant  
12 assessment of what we have and where things are  
13 in terms of priority, we have more people doing  
14 that, because each investigator has a case  
15 load, Intake Investigator, and they are  
16 constantly looking at what the priority is  
17 within there, so there is constant triaging  
18 going on.

19 Q. Right, so once something gets  
20 given to an investigator, the relative priority  
21 can rise or fall based on what else is coming  
22 in the pipeline?

23 A. That's correct.

24 Q. Okay, can you go to tab 9 of  
25 the yellow compendium of documents you have.  
26 This is document 36848, and this is the cover  
27 letter to the Caressant Care Woodstock report  
28 on Ms. Wettlaufer.

29 A. Yes.

30 Q. I am just going to wait for  
31 it to come up on the screen.

32 Am I to understand that the only

1 two ways that the College receives reports of  
2 this sort are via regular mail or via fax?

3 A. Yes.

4 Q. And typically, I assume, if  
5 you receive it via fax, there would be a fax  
6 header on the form?

7 A. I would expect that, yes.

8 Q. Do you believe that this  
9 letter was sent in via regular mail?

10 A. Yes, I do.

11 Q. Are most reports sent in via  
12 regular mail?

13 A. Yes, other than urgent  
14 reports, so urgent reports may -- typically, we  
15 would receive a phone call indicating it was  
16 coming, and it then would come by fax, followed  
17 by mail.

18 Q. So if you look at the final  
19 sentence of the first paragraph, it says:

20 "She was terminated due to a  
21 medication error which resulted  
22 in putting a resident at risk."

23 And I am wondering if that  
24 language of "putting a resident at risk"  
25 changes any urgency in the College's triage  
26 process?

27 A. Well, the College would do  
28 its own assessment, because all medication  
29 errors have the potential to put a resident at  
30 risk.

31 Q. Yes.

32 A. And so the College assessment

1 is what the level of risk is that that -- that  
2 the report suggests.

3 Q. Okay. Can we actually go  
4 back to tab 17 of the document you have there,  
5 which we have talked about already. It is  
6 document 36834. Again, that is the Reports  
7 Intake Assessment Form.

8 So just so I am clear, before  
9 July 23rd, 2014, you are suggesting that  
10 somebody else at the College would have  
11 reviewed this -- would have reviewed the report  
12 relating to Ms. Wettlaufer in order to figure  
13 out where in the priority it should be?

14 A. Yes, and in fact, now that I  
15 look at this again, what I can tell you is that  
16 this note that looks like it is -- if you  
17 scroll up on the screen a little bit, the note  
18 that looks like a Post-it note has been placed  
19 on the page. It says "Prior file in copy  
20 room". That is a note from the Intake  
21 Associate who has reviewed the initial --  
22 scroll down, sorry. Scroll down, sorry.

23 Q. You are saying that is from  
24 the Intake Associate?

25 A. Yes, who has --

26 Q. Who is Patty?

27 A. Yes.

28 Q. Okay. And what you are  
29 suggesting is Patty has done some sort of an  
30 initial review?

31 A. Yes.

32 Q. Is there any documentation of

1 when that initial review happens, any sort of  
2 record of that at all in terms of your  
3 processes? I am not speaking with respect to  
4 Ms. Wettlaufer specifically. I am talking  
5 generally with respect to your processes.

6 A. No, not that I am aware of.

7 I think what I want to be clear  
8 is that when a matter comes in, so it is the  
9 same individual who is date-stamping it, who is  
10 creating the file, who is looking to see are  
11 there prior -- is there prior information the  
12 College should be collecting. So it is done  
13 very close to the time of the matter being  
14 received by the College.

15 Q. And that hasn't changed  
16 between 2014 and today?

17 A. No.

18 Q. It is fair to say, though,  
19 that as of July 23rd, no one had had a  
20 substantive look at the file outside of that  
21 very initial triage moment you have discussed?

22 A. That is my understanding.

23 Q. Does the College maintain any  
24 service standards about an acceptable period of  
25 time between the receipt of a report and the  
26 file being given to an Intake Investigator for  
27 a substantive review?

28 A. The standard -- we don't have  
29 a time frame, if that is what you are asking  
30 me, in terms of a service standard.

31 Q. That is part of it, yes.

32 A. Because we are constantly

1 triaging to be able to address the most serious  
2 matters on an urgent basis.

3 Q. I can assume --

4 A. So what I --

5 Q. Sorry.

6 A. I'm sorry.

7 Q. No, please go right ahead.

8 A. What I indicated earlier is  
9 that our volumes are unpredictable, and we  
10 adjust as we can to accommodate for volumes,  
11 but our priority is on those matters that pose  
12 the most serious risk of harm to patients and  
13 residents.

14 Q. And I assume that gauging of  
15 serious risk is based on the accuracy of the  
16 report that you are initially provided by the  
17 employer?

18 A. That's correct.

19 Q. Is there any sort of outer  
20 boundary of time that you would deem to be  
21 unacceptable for an Intake Investigator to  
22 first be having a substantive review of an  
23 employer report?

24 A. Well, I think the team is  
25 currently looking at those outliers that I  
26 talked about. So when I said that my estimate  
27 is that we attend to matters within six months,  
28 there are some that are outliers, and earlier  
29 this year there were some that were a year old,  
30 and that would be unacceptable.

31 Q. Does the timing of where  
32 something -- sorry, does the placement of where

1 you put it in the pipeline, so how you triage  
2 something, is it affected at all by the  
3 underlying timing of the event which prompted  
4 the report? For example, here Ms. Wettlaufer  
5 was terminated on March 31st, and the report  
6 didn't land until May the 1st, which is  
7 actually slightly outside, I understand, the  
8 30-day period.

9 If something happened the day  
10 before and it was reported, for example, versus  
11 something that was slightly over 30 days  
12 reporting, does that period of time affect  
13 where something goes into your pipeline?

14 A. Not unless it coincides with  
15 the seriousness of the matter being reported.

16 Q. You have indicated that in  
17 some circumstances the first initial review for  
18 an Intake Investigator might take as much as  
19 six months?

20 A. It may.

21 Q. Do you think that members of  
22 the public would be disappointed in that time  
23 frame?

24 A. They may. I appreciate that  
25 they may be disappointed. What I want the  
26 public to appreciate is that the College is  
27 looking at the things that pose the most  
28 serious risk of harm, and there are many  
29 matters that are reported that in a different  
30 work setting would have been addressed in the  
31 workplace.

32 And so that is why our triaging

1 and continual prioritizing of matters is  
2 designed to make sure that action is taken to  
3 address in a -- that those matters that pose  
4 serious risk of harm are addressed on an urgent  
5 basis.

6 Q. Yesterday you were discussing  
7 with Ms. Jones, and it is actually in your  
8 affidavit as well, the College's resources.  
9 You said in 2018 that the College had 44 and a  
10 half million dollars in revenue; is that right?

11 A. That was our budget.

12 Q. Your budget, sorry.

13 A. That is not our revenue.

14 That is our annual budget.

15 Q. That is fair. How are you  
16 funded? Is it solely through the registration  
17 fees of your members, or do you --

18 A. It is.

19 Q. Okay. Given the swell of  
20 complaints that you discussed yesterday, do you  
21 feel that the College has the resources to  
22 adequately effect its self-regulatory function?

23 A. I just want to clarify that I  
24 referred to an increase in reports, so not in  
25 complaints. There is a minor -- there is a  
26 small increase in complaints, but the big  
27 increase has been in reports from employers.

28 And in terms of the resources  
29 that we have, we have -- in our forecast for  
30 our budget for 2019, we have identified that  
31 due to the increased volume we have seen this  
32 year, that we will need to increase our



1 resources and we have given notice to members  
2 that the membership fee is going up for 2019.

3 Q. You have talked about the  
4 differentiation between the power to compel  
5 documents as between an investigator versus an  
6 Intake Investigator, and in particular, the  
7 statute does not contemplate even the role of  
8 an Intake Investigator; would you agree?

9 A. That is correct.

10 Q. The College has created the  
11 role and the intake process to help guide the  
12 risk assessment and to guide your appropriate  
13 regulatory response; is that fair to say?

14 A. That's correct.

15 Q. Do you think that Intake  
16 Investigators should have the ability to compel  
17 documents?

18 A. No, I don't.

19 Q. Can you tell me why?

20 A. That is an -- the whole  
21 purpose of intake is that initial triage, and  
22 we want to be able to do it quickly so that we  
23 can quickly spot things that need that full  
24 power of a section 75, because those are the  
25 most -- the matters that potentially pose the  
26 highest risk of harm.

27 If we were to initiate section  
28 75 powers for every matter that came to the  
29 College's attention, that would hamper the  
30 College's ability to in a very timely,  
31 efficient manner address those most serious  
32 matters.

1 Q. Do you believe that an  
2 employer report -- sorry, do you believe it  
3 would be possible for an employer to send a  
4 copy of the relevant nurse's employment file  
5 along with their report to the College?

6 A. Could you ask the question  
7 again, please?

8 Q. I'll try and ask it in a  
9 different way, because I saw the Commissioner  
10 looking at me, so I'll try it a different way.

11 THE COMMISSIONER: I look at you  
12 from time to time.

13 BY MR. VAN KRALINGEN:

14 Q. Fair enough.

15 Do you think there would be  
16 value if the College, along with an employer  
17 report, had the ability to compel the employer  
18 to provide a copy of the entire employee file  
19 for the given nurse in question?

20 A. No, that would not be  
21 helpful, and that is why we are specific in our  
22 guidance to employers about specifically  
23 identifying the incidents which cause them  
24 concern about a nurse's conduct, competence or  
25 capacity, and we do indicate that they are free  
26 to attach documentation that supports those  
27 incidents.

28 Q. But in a scenario where the  
29 College receives inaccurate information from an  
30 employer, do you think having the capacity to  
31 look at the employee's entire file might allow  
32 you to try and reconcile some of those

1 inaccuracies or ask questions about  
2 inaccuracies?

3 A. Again, we need to be part of  
4 a system, and employers play a key role, and we  
5 are counting on employers to be able to assess  
6 what the critical matters are that pertain to a  
7 nurse's competence, capacity or conduct.

8 A whole employee file is not  
9 helpful because we are not then clear what are  
10 the specific concerns that the employer is  
11 flagging.

12 And again, we have already  
13 talked about the volume of matters that the  
14 College is dealing with, and one of the ways  
15 that we have -- one of the processes that we  
16 have put in place to support us to be able to  
17 in an efficient, timely way assess matters is,  
18 for example, the Employer Report Form, so that  
19 we receive information in a consistent way that  
20 allows for that quick assessment and triaging  
21 of matters coming in.

22 Q. I would like to move on to a  
23 different topic. I now want to talk about the  
24 relationship between the Ministry of Health and  
25 Long-Term Care's investigations or inspections  
26 and any possible reporting to the College.

27 To your mind, is there any legal  
28 barrier for someone who works as an inspector  
29 with the Ministry of Health and Long-Term Care  
30 in conjunction with the execution of their  
31 duties from reporting concerns about a  
32 Registered Nurse to the College?

1 A. I apologize, but I am not an  
2 expert in that legislation.

3 Q. You are not aware of any  
4 barriers, sitting here today?

5 A. I am not aware of a barrier.

6 Q. In the wake of Ms.  
7 Wettlaufer's abrupt departure from Meadow Park,  
8 there was a Ministry investigation as to  
9 missing narcotics; are you aware of that?

10 A. Yes, through this Inquiry.

11 Q. I appreciate that, yes.  
12 During the course of that  
13 investigation, the Ministry inspector was told  
14 about Ms. Wettlaufer's resignation, and also  
15 her note that she has an illness that will  
16 require treatment and she'll be unable to work  
17 as an RN following her treatment.

18 In terms of best practices, do  
19 you think that the Ministry should have shared  
20 that information with the College?

21 A. That would have been helpful  
22 information for the College to have,  
23 absolutely.

24 Q. Can you go to page 17 of your  
25 affidavit and paragraph 40, please. Thank you.

26 You talk about the initial  
27 declaration that nurses had to make in 1995 and  
28 then how that declaration has changed in 2013,  
29 namely, that they did not suffer from any  
30 physical or mental condition or disorder that  
31 would affect their ability to practice nursing.

32 And I want to understand, in a

1 practical sense, how useful is that question to  
2 the College?

3 A. It is very useful. For  
4 example, a nurse may disclose that she has a  
5 significant hearing deficit, and that could  
6 have an impact on the ability to practice  
7 safely and that allows the College to do an  
8 assessment and to make sure that the nurse is  
9 putting measures in place to accommodate for  
10 that hearing deficit.

11 Q. How often does the College  
12 receive such information in connection with  
13 that question about a physical or a mental  
14 condition or disorder that may affect their  
15 ability to practice nursing?

16 A. I can't give you a number,  
17 but it is a common check-box for applicants,  
18 and there are two ways that we get the  
19 information.

20 So there is the form that we  
21 reviewed yesterday.

22 And then at the time of writing  
23 the registration exam, applicants will  
24 sometimes ask for accommodations, and whenever  
25 an applicant asks for an accommodation, they  
26 are advised that, along with the review of the  
27 accommodation request, the College will also  
28 assess whether the need for an accommodation  
29 relates to their ability to practice safely.

30 Q. In the context of an  
31 untreated addiction issue, would you agree with  
32 me that the question is not particularly

1 helpful, as it is unlikely the nurse would  
2 disclose?

3 A. I'm sorry, could you ask the  
4 question again, please?

5 Q. Certainly. In the context of  
6 an untreated addiction issue, would you agree  
7 with me that the question is not particularly  
8 helpful because the nurse is unlikely to  
9 disclose?

10 A. You are correct that it may  
11 be unlikely that an untreated addiction issue  
12 may not be disclosed because of the nature of  
13 the disease and the lack of insight. However,  
14 it may well be identified during the student  
15 clinical -- their education practice, or it may  
16 be uncovered during a criminal background  
17 check.

18 So it is unfortunately quite  
19 common for applicants to have on their criminal  
20 background record driving under the influence  
21 charges, and so we would review court documents  
22 which often have information that would alert  
23 the College to an untreated alcohol addiction.

24 Q. Could you go to tab 27 of the  
25 documents I provided you, and this is document  
26 36293. This is Ms. Wettlaufer's 2015 Annual  
27 Membership Renewal. I am going to ask you,  
28 once you pull it up, to cycle to the bottom of  
29 the page, please.

30 You will see at the bottom of  
31 the page that this was submitted on December  
32 29th, 2014, at 12:45 p.m. I assume that the

1 College has some sort of an electronic process  
2 that tracks this; is that fair to say?

3 A. Yes, this renewal would have  
4 been completed online.

5 Q. And you will see and we were  
6 talking a little earlier about the idea of the  
7 employment summary, and it says "Employment  
8 Summary" with respect to Ms. Wettlaufer and it  
9 references Meadow Park; it says the start date  
10 and end date of April 2014 and then the end  
11 date of September 2014.

12 My first question is what is the  
13 purpose of having the employment summary here?

14 A. It is part of the data  
15 collection that the College does on behalf of  
16 the Ministry for their health human resource  
17 planning work.

18 Q. Who sees this document or the  
19 information aggregated from these documents at  
20 the College?

21 A. Well, our stats department  
22 does an aggregate, but then this information is  
23 submitted to the Ministry, the Ministry  
24 database.

25 Q. Of course, as you were  
26 reviewing earlier today, only a few months  
27 earlier in October 2014 the College sent Ms.  
28 Wettlaufer a letter banking the information  
29 received from Caressant Care.

30 So I am wondering, does the  
31 College look at the information that Ms.  
32 Wettlaufer was employed for only four months at

1 Meadow Park after she was terminated from  
2 Caressant Care and take any steps to learn  
3 about the circumstances of her departure?

4 A. No, I want to be clear that  
5 these individual forms are an administrative  
6 process, and they are not individually  
7 reviewed. That information is health human  
8 resource data that is supplied to the Ministry  
9 in terms of the start and end date, and it also  
10 will trigger the information on Find a Nurse  
11 about the nurse's current business address.

12 Q. Could you go to tab 4 of the  
13 yellow document brief you have in front of you.  
14 This is document 37259.

15 THE COMMISSIONER: What tab, I'm  
16 sorry?

17 MR. VAN KRALINGEN: Tab 4.

18 THE COMMISSIONER: Thank you.

19 BY MR. VAN KRALINGEN:

20 Q. You are welcome.

21 From what I can see, this  
22 document is called "Summary of Investigation",  
23 and what it appears to me to be is an  
24 aggregation of Ms. Wong's notes - and Ms. Wong  
25 was the investigator for the College during the  
26 Geraldton issue - an aggregation of her notes,  
27 including information she had received from the  
28 health care workers at Geraldton around the  
29 incident of Ms. Wettlaufer's suicide attempt.

30 I would like you to go to page  
31 11, please. At page 11 there is a fellow  
32 nurse, Ms. Gagné.



1                   A. I'm sorry, at page 11 --  
2                   Q. So you are in tab 4, and page  
3 11, what you will see on the bottom right-hand  
4 corner is the document number and then a dash  
5 to certain page numbers.  
6                   A. Thank you.  
7                   All right, thank you.  
8                   Q. This was a conversation  
9 between Ms. Gagné and Ms. Wettlaufer as Ms.  
10 Wettlaufer was being treated, and if you could  
11 just cycle down a little on the page - thank  
12 you - you will see near the bottom that Ms.  
13 Gagné asks Beth:  
14                   "[...] did you have or have you  
15 taken any street drugs?"  
16                   And Ms. Wettlaufer says:  
17                   "Yes, hash about 4 weeks ago."  
18                   And I think that that is a short  
19 form for hashish; would you agree?  
20                   A. Yes.  
21                   Q. It says:  
22                   "Client remains crying."  
23                   Ms. Gagné says:  
24                   "What's wrong? Are you scared  
25 of something or someone?"  
26                   The client says, "Yes".  
27                   And if you go over to the next  
28 page, the client says -- or Ms. Gagné says,  
29 "Who?"  
30                   The client says, "Ron Von  
31 Stook."  
32                   Ms. Gagné says, "Who's Ron Von

1                   Stook."  
2                   And the client says:  
3                   "He's evil. If he doesn't like  
4                   you. He hunts you down & when  
5                   he gets a hold of you. He ties  
6                   you up & then he tears you're  
7                   [sic] skin off & runs runs some  
8                   sharp thing under your feet."  
9                   My first question is with  
10                  respect to the issue of the use of street  
11                  drugs.

12                                 It seems that Ms. Wong has  
13                                 learned a little bit about some history of the  
14                                 use of street drugs, and I am wondering, if an  
15                                 investigator learns about the use of street  
16                                 drugs and that is not consistent with reports  
17                                 that are subsequently given, either through the  
18                                 nurse's counsel or through the reports that are  
19                                 put together by psychologists or addiction  
20                                 specialists, to what extent does the College  
21                                 intervene and say we think we have got  
22                                 different information?

23   A. So all of the information  
24   that the investigator collects is provided to  
25   the independent medical examiner, and it is --  
26   the independent medical examiner is appointed  
27   or approved by the Inquiries, Complaints and  
28   Reports Committee. In this case, it would have  
29   been the Executive Committee. And the panel  
30   relies on the expert assessment and the expert  
31   advice of the independent medical examiner.

32   Q. I assume that the importance

1 of giving that information would be that the  
2 use of street drugs followed by the overdose of  
3 prescription drugs could be relevant to an  
4 addiction analysis; would you agree?

5 A. Yes.

6 Q. If you could go to the next  
7 tab, tab 5, which is document 37305. This is a  
8 December 13, 1995 letter from Ms. Wettlaufer's  
9 then lawyer Ms. McIntyre. In the third  
10 paragraph, the second sentence, Ms. McIntyre  
11 says:

12 "She has no history of drug  
13 addiction or of drug usage."

14 And so in the context of a  
15 capacity concern, to what extent is it a  
16 concern for the College when a nurse or their  
17 counsel inaccurately characterizes the nurse's  
18 medical history or drug use history?

19 A. Well, the College has -- this  
20 is one piece of information that informs the  
21 College's assessment. It is not definitive,  
22 and we would not rely on the report of the  
23 member's counsel or the member's personal  
24 treating health professional.

25 We would ensure that there was  
26 an independent assessment of the information  
27 that the College had and of the member's  
28 health.

29 So it is possible that counsel  
30 was told by the client that they have no  
31 history of drug addiction or drug usage.

32 Q. And you are confident that

1 the independent medical examiner would have  
2 received the entirety of Ms. Wong's report?

3 A. Yes, that is our process.

4 Q. That is your process.

5 Can you go to tab 7 of the  
6 documents you have there. This is the  
7 Memorandum of Agreement between the College of  
8 Nurses and Ms. Parker, and it is document  
9 36838.

10 Now, one of the things I note is  
11 that we are getting close to two years from the  
12 date of the initial incident when Ms.  
13 Wettlaufer had the overdose at Geraldton  
14 Hospital, and just for my understanding, is  
15 that a typical time frame to come to an  
16 agreement in the context of a capacity issue  
17 that the College is investigating?

18 A. It may have been at that  
19 time. I honestly don't know. And I would  
20 think that that is probably the longest time  
21 that it would take.

22 It really depends on the ability  
23 to get health records, to schedule appointments  
24 with medical experts, and so that process can  
25 take time.

26 What I will tell you is that --  
27 and I am speaking now to our current process.

28 Q. Yes.

29 A. Is that there is an  
30 assessment by the Inquiry's Complaints and  
31 Reports Committee panel to determine whether  
32 there is current concern about risk of harm,

1 and it is very often that counsel will provide  
2 assurances to the panel that the member is not  
3 practising and will not practise until the  
4 matter is resolved.

5 Q. Well, let's actually talk  
6 about what happened after Geraldton. In that  
7 interim period, Ms. Wettlaufer was practising  
8 and she was working with a different kind of  
9 vulnerable population, but a vulnerable  
10 population nonetheless.

11 During that time, what sort of  
12 monitoring, if any, did the College provide  
13 before this Memorandum of Agreement was entered  
14 into?

15 A. I am only going on what I  
16 have seen in the record --

17 Q. I understand.

18 A. -- and my understanding of  
19 the process at the time, and that was that the  
20 process was unfolding. So I can't assist you  
21 with any additional information about  
22 monitoring.

23 Q. Because this Memorandum of  
24 Agreement contemplates providing notice to her  
25 then employer, Christian Horizons?

26 A. That's correct.

27 Q. But it doesn't contemplate  
28 any notice to the Geraldton District  
29 Association we were talking about, that care  
30 home?

31 A. That's correct, and that is  
32 one of the reasons that the College advocated

1 for, along with other regulators, to have the  
2 legislation changed so that there was the  
3 opportunity for earlier consideration of  
4 interim suspension or terms, limits and  
5 conditions.

6 Q. With respect to the Schedule  
7 "A", could you go to paragraph numbered 13 in  
8 the Schedule "A". It is three pages from the  
9 back, if that is helpful, of that tab, within  
10 that tab.

11 A. Which tab? Oh, the same tab?

12 Q. The same tab, three pages  
13 from the back within that tab.

14 A. Thank you.

15 Q. So 13. Thank you. This  
16 talks about the length of time that the  
17 conditions shall stay in force. It says,  
18 though, halfway through the paragraph:

19 "The length of time the[se]  
20 conditions are in effect may be  
21 extended beyond one year, should  
22 the College receive information  
23 that the Member has relapsed to  
24 the use of alcohol."

25 So my question is if Meadow Park  
26 had informed the College of Nurses that Ms.  
27 Wettlaufer had disclosed to them an alcohol  
28 problem, could this order have been revived in  
29 any way?

30 MS. CORRENTE: I am going to  
31 object to that on the basis that  
32 it is speculative. I don't

1 believe that we have established  
2 with this witness that there was  
3 any mandatory reporting  
4 obligation in view of the  
5 legislation, the current  
6 legislation that was put to her,  
7 rather than the legislation that  
8 existed at the time.  
9 And in the absence of any  
10 obligation to report, I think it  
11 is quite speculative to  
12 speculate on what the College  
13 would have done if it would have  
14 received information that would  
15 have been voluntary, especially  
16 in view of the fact that this  
17 witness has testified that as  
18 part of the assessment process,  
19 the information that is looked  
20 at includes a report from the  
21 employer, which would not have  
22 existed if there was no  
23 mandatory report, and  
24 discussions with the reporter  
25 which would not have happened if  
26 there is no reporter.  
27 So there is a lot of "if's", if  
28 this and if that, and I think  
29 that it is just a very, you  
30 know, speculative line of  
31 questioning in view of evidence  
32 that has not been given.

1 MR. VAN KRALINGEN: Sorry, I  
2 want to be clear, I don't  
3 concede at all that there wasn't  
4 a mandatory obligation to report  
5 or an obligation on Meadow Park  
6 to report. But my simple  
7 question was if a report had  
8 been made, would there be an  
9 implication of paragraph 13?  
10 MS. CORRENTE: Well, I find that  
11 questioning problematic because  
12 we first need to establish that  
13 there was an obligation to make  
14 a mandatory report, which hasn't  
15 been established, so --  
16 THE COMMISSIONER: Well, I don't  
17 understand that as a foundation.  
18 He is just saying if there had  
19 been, wasn't the question --  
20 MR. VAN KRALINGEN: That is  
21 exactly right.  
22 THE COMMISSIONER: Not whether  
23 if it was required or anything,  
24 but just if there had been a  
25 report.  
26 MS. CORRENTE: I still think  
27 that if there had been a report,  
28 it would have been -- it is a  
29 speculative line of questioning  
30 in view of the fact that this  
31 witness has testified about the  
32 process for assessment when



1                   there is a report, and that  
2                   includes looking at a report  
3                   which we don't have and speaking  
4                   to people which have not been  
5                   able to give information.  
6                   So how can you come to an  
7                   assessment as to risk in the  
8                   absence of that kind of  
9                   information?

10                  MR. VAN KRALINGEN: This doesn't  
11                  say a report. It says  
12                  "information".

13                  THE COMMISSIONER: So and your  
14                  question again was, if it had  
15                  received, if the College had  
16                  received information about the  
17                  relapse in the use of alcohol,  
18                  was that what you were saying?

19                  MR. VAN KRALINGEN: Yes.

20                  THE COMMISSIONER: Then what  
21                  would it have done? Do you have  
22                  to tie your question to Meadow  
23                  Park?

24                  MR. VAN KRALINGEN: No, but I  
25                  live in the real world, and we  
26                  know that this happened after  
27                  Meadow Park. Like let's --

28                  THE COMMISSIONER: But --

29                  MR. VAN KRALINGEN: Well, I can  
30                  put it in the abstract.

31                  THE COMMISSIONER: Yes, and I  
32                  think that is what we want to

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know.

MR. VAN KRALINGEN: That's right.

THE COMMISSIONER: It doesn't matter how. But if the College had become aware that the member had relapsed with the use of alcohol, what was the balance of your question?

BY MR. VAN KRALINGEN:

Q. Could paragraph 13 of this Memorandum of Agreement have been revived?

A. Only if that happened during the monitoring period. So once the monitoring period concluded and the independent medical examiner identified that the member was fit for work, this process came to an end and information -- future information would trigger a new health inquiry.

Q. Just so I'm clear, have you received legal advice on that, or is that your interpretation of the document?

A. I have not received legal advice, but my understanding is that health inquiries, you can't re-open an undertaking. You have to -- once the undertaking comes to an end and the term has ended, then if there -- let's say it is a year later, then the College would initiate a new health inquiry.

Q. Can you go to tab 10 of the yellow brief of documents you have got before you. This is document 36841. This is the

1 Report Form for the Facility Operators and  
2 Employers.

3 THE COMMISSIONER: What tab  
4 again, Counsel?

5 BY MR. VAN KRALINGEN:

6 Q. Tab 10, please.

7 I am going to just start with an  
8 obvious question. I assume -- can I assume  
9 that your expectation is that the employer  
10 lists the nurse's entire discipline history?

11 A. Our expectation is that the  
12 employer lists the incidents which give cause  
13 for concern about the nurse's safety to  
14 practice.

15 Employers discipline employees  
16 for a variety of reasons, so we do not  
17 characterize the information as a way to  
18 determine what to report to the College.

19 Q. Can you look at the  
20 second-last page within that tab, and I believe  
21 it is page 13. This is the August 29, 2012 --  
22 or reference to the August 29th, 2012 incident,  
23 and you will agree with me that there was no  
24 reference within this entry to a concern about  
25 resident safety?

26 A. There is no concern, is that  
27 your question?

28 Q. That there is no concern  
29 within this entry with respect to resident  
30 safety?

31 A. That's correct.

32 Q. Can you go to tab 21 of the

1 documents that you have, and this is document  
2 16823.

3 A. Yes.

4 Q. This is a Disciplinary Action  
5 Form that the Intake Investigator would not  
6 have had in 2014; correct?

7 A. That's correct.

8 Q. And it is in connection with,  
9 although it is dated August 31, it is in  
10 connection with an incident dated August 29th;  
11 do you see that?

12 A. Yes.

13 Q. Can you cycle down to the  
14 bottom of the page?

15 On the bottom left-hand portion  
16 of the page it indicates:

17 "Explained to Bethe that she  
18 brought her health issues to us  
19 and we are obliged to ensure the  
20 safety of the residents."

21 Do you see that?

22 A. Yes, I do.

23 Q. If Caressant Care had a  
24 concern about resident safety in connection  
25 with this particular incident, do you believe  
26 they should have included it on the Employer  
27 Report Form?

28 A. Absolutely.

29 Q. Within the narrative in the  
30 middle of the page - and just a little bit  
31 down, if you don't mind, perfect - there is a  
32 reference in the second sentence that says:

1 "If continued poor work  
2 performance related to health  
3 issues continue, consideration  
4 may be given to report to the  
5 College of nurses for 'fitness  
6 to practice for review'."

7 To your mind, is the reference  
8 to the fitness to practice for review a  
9 discretionary decision on behalf of the  
10 employer or is it a mandatory decision?

11 A. If there are concerns about  
12 the capacity, and that is what our fitness to  
13 practice process engages, then that is a  
14 mandatory report.

15 Q. Ms. Yee did not have this  
16 document in 2014?

17 A. She did not.

18 Q. If she had this document, do  
19 you think she could have compared it to the  
20 Employer Report Form and perhaps asked some  
21 pointed questions about this incident?

22 A. Yes, I do.

23 Q. Could you go to tab 13 of the  
24 documents you have. Can you explain the  
25 circumstances where there is a 30-day reporting  
26 period versus the immediate reporting  
27 obligation? We'll get to the documents in a  
28 moment. I just want your --

29 A. Oh, I'm sorry, I thought  
30 you --

31 Q. That's all right. Can you  
32 give me your best understanding of when there

1 is the 30-day obligation versus the immediate  
2 obligation?

3 A. The immediate obligation is  
4 where there is a continued risk, where the  
5 individual poses a continued risk of harm to --

6 Q. And we discussed that and we  
7 discussed what "continued risk" means earlier  
8 today?

9 A. Yes.

10 Q. I'm going to ask you to pull  
11 up the transcript of Ms. Hepting's  
12 cross-examination.

13 For your notes and your record,  
14 Madam Commissioner, it is Day 16, June 27th,  
15 and it is page 3735 and 3736, starting at line  
16 25.

17 Could you cycle down?

18 I'm just going to review a small  
19 excerpt of Ms. Hepting's cross-examination, and  
20 then I'm going to ask for your response as to  
21 whether you believe Caressant Care should have  
22 reported immediately or should have reported on  
23 the 30-day time frame.

24 Before doing that, let's look  
25 at -- well, there is a reference to an email  
26 that I will show you in a second, but it says:

27 "Question: And in your email,  
28 as we reviewed earlier today,  
29 second from the top you  
30 indicate:

31 '[...] she appears to be a  
32 danger to resident's welfare.'

1 I assume you believed that at  
2 the time you wrote it.

3 Answer: Yes.

4 Question: And you will agree  
5 with me that as of this day, you  
6 believe that Ms. Wettlaufer  
7 would be a danger to any  
8 resident anywhere?

9 Answer: As of?

10 Question: This date, as of the  
11 date you wrote this note, did  
12 you believe that Ms. Wettlaufer  
13 would be a danger to any  
14 resident anywhere?

15 Answer: Well, I was concerned  
16 about our residents, but yes.

17 Question: And just to  
18 understand your answer, you were  
19 particularly concerned about  
20 your residents, but you also  
21 assumed that she would be a  
22 danger to any resident anywhere?

23 Answer: Given the history that  
24 I had in front of me of her  
25 disciplines, yes."

26 If Ms. Hepting, as of March 31,  
27 2014, as the Vice President of Operations for  
28 Caressant Care felt that Ms. Wettlaufer would  
29 be a danger to any resident anywhere she  
30 subsequently would have worked, to your mind,  
31 would that have required Caressant Care to make  
32 an immediate report to the College?

1                   A. Yes, it would, and that  
2 report should include the fact that they were  
3 of the belief that she did pose a danger to  
4 residents.

5                   Q. Do you believe that the  
6 manner in which Caressant Care reported Ms.  
7 Wettlaufer's termination reflected that  
8 urgency?

9                   A. No, it did not.

10                  Q. During the course of the  
11 College's intake investigation, was --  
12 actually, go to tab 11, document 72096. Let's  
13 just pull up the email that I was just  
14 referencing in my question to you.

15                  This was an email between the  
16 four members of Caressant Care's most senior  
17 management team. The second email from the top  
18 was Ms. Hepting indicating that "[...] she  
19 appears to be a danger to [a] resident's  
20 welfare", and the top email is from  
21 Mr. Dengate, the VP of Finance, indicating that  
22 "[...] her actions are very dangerous."

23                  During the course of the  
24 College's intake investigation, was this email  
25 brought to Ms. Yee's attention?

26                  A. No, it was not.

27                  Q. Would you have expected it to  
28 be brought to Ms. Yee's attention?

29                  A. I would have expected --

30                  MR. GOLDEN: I have a -- this is  
31 where I have a problem. We had  
32 a lot of evidence over the fact



1                   that Tim Dengate is an  
2                   accountant, not a nurse. This  
3                   witness does not know that.  
4                   We also know that Ms. Hepting is  
5                   specifically referring to the  
6                   incident which led to the  
7                   termination. And out of  
8                   context, she is being shown this  
9                   email without having any of that  
10                  context.

11                 And you know, yes, we can have a  
12                 debate and we will have a debate  
13                 over whether when a cover letter  
14                 says "putting residents at risk"  
15                 is sufficient or not, but to  
16                 show and point to Tim Dengate,  
17                 who was a financial officer, and  
18                 without this witness knowing and  
19                 hearing that evidence and to  
20                 draw an inference from it, I  
21                 don't think it is fair.

22                 THE COMMISSIONER: I am troubled  
23                 by the absence of a foundation  
24                 for this. I mean, it is quite  
25                 different. And my understanding  
26                 is that the underlying incident  
27                 that has triggered this email  
28                 chain is disclosed in the -- it  
29                 is the very first incident. It  
30                 is the incident that led to the  
31                 termination, right?

32                 MR. VAN KRALINGEN: I understand

1                   that. All I'm asking is whether  
2                   this email should have been --  
3                   was this email provided to Ms.  
4                   Yee and whether Ms. Coghlan  
5                   thinks it should have been  
6                   provided to Ms. Yee, because it  
7                   goes towards the question of  
8                   urgency, even if it is one issue  
9                   or many issues.

10                  THE COMMISSIONER: I am not  
11                  comfortable with the foundation  
12                  that has been laid for this  
13                  witness, frankly.

14                  I mean, the incident that  
15                  prompted the termination is the  
16                  very incident that is under  
17                  discussion in these emails, and  
18                  clearly the Director of Nursing  
19                  and the Administrator thought  
20                  that it was worth terminating  
21                  her for. So they gave that  
22                  information to the College.  
23                  And so what are you asking, that  
24                  they should have included an  
25                  email exchange amongst the head  
26                  office people that agreed that  
27                  she should be terminated before  
28                  they terminated her?

29                  MR. VAN KRALINGEN: I actually  
30                  think if it goes to the question  
31                  of urgency of the issue, I  
32                  actually do think so, because

1 the way it is framed right now,  
2 it is framed as it is mailed; it  
3 is within the 30-daytime frame.  
4 THE COMMISSIONER: I don't have  
5 any problem with your question  
6 which was based on this, the  
7 last question of whether it  
8 should be urgent.  
9 But what I am saying is I don't  
10 understand how the email is  
11 attached to the question of the  
12 report. It is in the report.  
13 It is the terminating event, and  
14 it is there. The report doesn't  
15 require a chain of emails behind  
16 it.  
17 So are you suggesting -- that's  
18 my problem.  
19 MR. VAN KRALINGEN: I am going  
20 to move on, actually.  
21 MS. ROTHSTEIN: Commissioner, I  
22 was just going to say that I  
23 actually think it might be of  
24 some benefit to you to hear from  
25 Ms. Coghlan because she has told  
26 you that the way employers view  
27 events and how they characterize  
28 them is actually very important  
29 to the College and it relies on  
30 it, because termination isn't  
31 the same as dangerousness.  
32 But I think it would be

1 interesting actually just to  
2 hear from her whether it changes  
3 her view that it is from an  
4 accountant as opposed to a  
5 Director of Nursing. I think I  
6 have a sense of what she might  
7 say about that, but it might be  
8 of some benefit to you to know.

9 MR. VAN KRALINGEN: It is  
10 actually my examination and I  
11 would like to move on, if that  
12 is all right.

13 MS. ROTHSTEIN: Okay, fair  
14 enough. Fair enough.

15 BY MR. VAN KRALINGEN:

16 Q. Thank you. If we could go to  
17 tab 13 of the documents you have. This is the  
18 Mandatory Reporting Guide, and it is document  
19 60161, and I want it to be clear this is the  
20 reporting guide that was in effect at the time  
21 of Ms. Wettlaufer's termination from Caressant  
22 Care.

23 I just want to understand, you  
24 have an understanding of the role of an  
25 administrator at a long-term care home; is that  
26 fair to say?

27 A. I do. I wouldn't say it is  
28 an expert understanding, but I have a general  
29 understanding.

30 Q. And similarly, you have an  
31 understanding of the role of a Director of  
32 Nursing, sometimes called a Director of Care at

1 a long-term care home?

2 A. I do.

3 Q. I wasn't clear from  
4 yesterday, do you believe that those two people  
5 would qualify as facility operators pursuant to  
6 this Mandatory Reporting Guide?

7 A. Facility -- yes.

8 Q. Okay.

9 A. Yes.

10 Q. And similarly --

11 A. Because that -- they are  
12 operating a facility where nursing care is  
13 being provided.

14 Q. And do you see any  
15 distinction between the local Administrator and  
16 the local Director of Nursing or Director of  
17 Care at an individual long-term care home and  
18 management of a company that has numerous  
19 long-term care homes? Could those members of  
20 management also be facility operators under  
21 this mandatory reporting scheme?

22 A. Yes, they could be. That, as  
23 I think I said yesterday, that is up to the  
24 organization to decide how they meet their  
25 obligation under the legislation for facility  
26 operators.

27 Q. With respect to employers,  
28 you were talking about with Ms. Jones the idea  
29 of somebody being a facility operator but  
30 somebody who actually pays the nurse, an  
31 external agency of some sort, placing someone  
32 there.

1                   In some circumstances, in  
2                   certain statutory codes and even in the common  
3                   law, there can be multiple people who can be  
4                   deemed to be an employer, and I am wondering,  
5                   to your mind, is it possible under this  
6                   Mandatory Reporting Guide that both the  
7                   facility and an external provider of the nurse  
8                   can both qualify as an employer for the  
9                   purposes of mandatory reporting?

10                   A. There are times when that is  
11                   the case.

12                   Q. Do you provide any guidance  
13                   to either external providers or facilities who  
14                   use external providers about their role as an  
15                   employer pursuant to this Mandatory Reporting  
16                   Guide?

17                   A. I am not sure I understand  
18                   your question, I'm sorry.

19                   Q. Is there any guidance ever  
20                   provided to either an external provider of  
21                   nurses to facilities, such as Lifeguard  
22                   Homecare, or facilities themselves who employ  
23                   external nurses that they might jointly be  
24                   employers for the purposes of this mandatory  
25                   reporting scheme?

26                   A. So the Mandatory Reporting  
27                   Guide is an attempt by the College to assist  
28                   employers and facility operators to understand  
29                   their obligations, and we also respond to  
30                   inquiries and encourage employers or facility  
31                   operators who have questions about their  
32                   obligations to call the College for assistance.

1 Q. Can you go to tab 15 of the  
2 documents that you have before you. That is  
3 document 60138. It is called Reports Intake  
4 Process, prepared by Andrea Boddy in April of  
5 2010. Can you just tell me the purpose of this  
6 document and what it is used for?

7 A. So this was prepared by an  
8 investigator at the time to document the  
9 process. It was used for orientation of new  
10 investigators and also to -- as a reference  
11 document for use by investigators.

12 Q. If you could go to page 5, it  
13 contemplates in the middle of the page "Making  
14 Inquiries of Former/Current Employer (Other  
15 Than the Reporter)", and it indicates:

16 "We will often call other former  
17 or current employers of the  
18 member if this information would  
19 assist us in determining the  
20 appropriate response by the  
21 College"?

22 A. That's correct.

23 Q. What guidance do you give --  
24 pardon me, what guidance does the College give  
25 to its Intake Investigators to determine  
26 whether a current employer could provide  
27 helpful information?

28 A. That is the judgment that  
29 they exercise as they are going through their  
30 risk assessment.

31 Q. And so the answer is there is  
32 no guidance; you just assume that people are

1 going to use their best judgment in these  
2 moments?

3 A. I am not aware of specific  
4 guidance, but it may well be part of the  
5 orientation and mentoring that they receive  
6 from other investigators.

7 Q. Can you please go to tab 19  
8 of the documents you have. This is document  
9 36847. This is the summary prepared on July  
10 30th by Karen Yee after her contact with Ms.  
11 Crombez, and just so I'm clear, do you receive  
12 this document at any point?

13 A. Yes, it was part of the  
14 intake file that I received.

15 Q. I see. So there is a  
16 reference to the mood-related or anxiety  
17 condition, if you go down. Thank you.

18 Was there ever an effort on your  
19 part to try and better understand the nature of  
20 that condition?

21 A. No, not that I recall.

22 Q. It also says a few bullets  
23 down that:

24 "The reported incidents go back  
25 to 2012."

26 If there had been further  
27 details on incidents before 2012, do you  
28 believe it would have affected your process and  
29 your review of this document?

30 A. I would say that it would  
31 depend on the nature of those incidents.  
32 Having now seen prior incidents, yes, it would



1 have had an impact.

2 Q. Can you go to the second  
3 page, please. Three bullets down on the second  
4 page it says:

5 "There was no sustained harm to  
6 the residents involved in the  
7 incidents."

8 How significant was that comment  
9 to your review?

10 A. I would say that it is a  
11 minor consideration. As I said earlier, the  
12 potential risk of harm is -- it factors into my  
13 consideration.

14 Q. Well, does actual harm factor  
15 in --

16 A. And actual, absolutely.

17 Q. That is what I was trying to  
18 suggest.

19 A. Yes.

20 Q. If there had been a  
21 discussion of actual harm as opposed to a  
22 comment that there was no sustained harm, would  
23 that have affected your review in any way?

24 A. Depending on the nature of  
25 the harm, yes, it would have, yes.

26 And just to be clear, and this  
27 may be helpful, harm can take a lot of  
28 different forms. So if I see a comment "no  
29 sustained harm" but a client has been  
30 embarrassed, I consider that harm. So that is  
31 what I just want to be clear about.

32 Q. Could you go to tab 23 of the

1 documents you have before you. It is document  
2 17578. This is the letter dated September  
3 25th, 2014, from Ms. Wettlaufer to Meadow Park.  
4 And I'll just let everyone pull it up,  
5 actually.

6 We have seen this before. The  
7 last sentence says that Ms. Wettlaufer was  
8 tendering her resignation effective October 15,  
9 2014; do you see that?

10 A. Yes, I do.

11 Q. And so in effect, Ms.  
12 Wettlaufer was providing a period of working  
13 notice or notice of some sort to Meadow Park;  
14 would you agree?

15 A. That is possible.

16 Q. For the purposes of the  
17 College's mandatory reporting requirements, on  
18 September the 26th, the day after, would you  
19 have deemed Ms. Wettlaufer to have been working  
20 for Meadow Park?

21 A. Well, if she is tendering her  
22 resignation effective October 15th, then she  
23 still is in their employ on September 26th.

24 Q. Can you go to the next tab  
25 then, tab 24. This is document 53318.

26 THE REPORTER: Mr. Van  
27 Kralingen, would you mind if we  
28 had a moment to switch our audio  
29 feed and to switch reporters?

30 MR. VAN KRALINGEN: Of course  
31 you can, yes.

32 -- RECESSED AT 4:08 P.M.

1                   -- RESUMED AT 4:08 P.M.  
2                   BY MR. VAN KRALINGEN:  
3                   Q. This is a report from the  
4 London Police Service, and although it  
5 indicates -- and the report is dated  
6 October 2nd, 2014, and when we had Ms. Nicholas  
7 on the stand, she indicated that she believes  
8 that this actually reflects a report of the  
9 London Police Service talking to multiple  
10 people from Meadow Park. The second page says,  
11 if you look at it, it says:

12                   "Why do you believe Elizabeth is  
13 responsible?"

14                   And when we say "responsible,"  
15 we're talking about taking the narcotics at the  
16 time. The answer is:

17                   "Yesterday afternoon, Bethe came  
18 into my office. She had  
19 resigned to say she was leaving  
20 us for medical reasons, and her  
21 last day is to be October 15,  
22 2014. And so she worked  
23 September 26, 2014. It's on the  
24 roster. She came into my office  
25 yesterday. I asked Valerie to  
26 be in the office. She had  
27 missed days at work. She had  
28 brought a doctor's note in and  
29 said she has an alcohol and drug  
30 problem, and she said she almost  
31 died last weekend."

32                   So my question to you is this:

1 If Ms. Wettlaufer had disclosed an alcohol and  
2 drug problem during her period of working  
3 notice, do you believe that Meadow Park should  
4 have reported that.

5 A. Yes.

6 Q. My next question is with  
7 respect to the standard of proof that a home  
8 must have with respect to an allegation of  
9 stealing medication. If a long-term care home  
10 has reasonable grounds to believe that a nurse  
11 has stolen hydromorphone, are those reasonable  
12 grounds alone enough to prompt a report to the  
13 College?

14 A. Yes.

15 Q. So the College does not  
16 require certainty as to whether the nurse stole  
17 the drugs in question?

18 A. Not at that stage. The  
19 College would conduct its own investigation.

20 Q. If you go to tab 25 of the  
21 documents you have?

22 THE COMMISSIONER: Sorry. The  
23 matters under investigation by  
24 the police, the College would  
25 investigate?

26 THE WITNESS: Sorry, I wasn't  
27 clear that the matter was under  
28 investigation by the police. If  
29 that was the case, then we would  
30 wait for the police  
31 investigation, but we would  
32 initiate our own investigation.

1 THE COMMISSIONER: Okay, that's  
2 what I thought. I just thought  
3 it would be clear because  
4 otherwise, it sounded like they  
5 would initiate.

6 BY MR. VAN KRALINGEN:

7 Q. I appreciate that. Thank  
8 you. If we go to tab 25 of the documents you  
9 have, and this is Document 17598.

10 This is an e-mail from  
11 Heather Nicholas, who was the director of care  
12 at Meadow Park, to Jennifer Brown, who was a  
13 care services co-ordinator at Jarlette Health  
14 Services, and just for your benefit, Jarlette  
15 owns Meadow Park. But halfway through the  
16 e-mail, it says:

17 "The RN in question  
18 interestingly had come to me on  
19 September 30th, 2014, to me that  
20 she had a terrible weekend and  
21 had been in hospital with an  
22 overdose and that she had an  
23 alcohol and drug addiction. I  
24 did convey that to the police."

25 Just so I'm clear based on our  
26 earlier conversation about facility operators,  
27 do you believe that Jarlette Health Services  
28 should have reported this to the College?

29 A. Yes.

30 Q. During the course of my  
31 conversation with Ms. Nicholas, she indicated  
32 to me that she had an expectation that

1 Ms. Wettlaufer would self-report or  
2 self-disclose her alcohol and drug problem to  
3 the College.

4 Given your experience, in your  
5 opinion, is it reasonable for an employer or  
6 facility operator to wait for a nurse to  
7 self-disclose an alcohol and drug problem?

8 A. No, it's not. The nature of  
9 the disease is such that the nurse often lacks  
10 insight and the ability to make that judgment.

11 Q. Luckily for you, my last  
12 document is tab 26. It's Document 36840. This  
13 is the October 14, 2014, letter from the  
14 College indicating that they were going to bank  
15 the information with notice.

16 Based on your experience, if the  
17 College been informed of the circumstances of  
18 Ms. Wettlaufer's departure from Meadow Park  
19 before October 14th, do you believe that the  
20 content of this letter would have changed?

21 A. Yes. The letter would be  
22 advising the member that Section 57 inquiry was  
23 being commenced, which is a health  
24 investigation.

25 Q. And based on our experience,  
26 if after October 14, 2014, if you had learned  
27 about the circumstances surrounding  
28 Ms. Wettlaufer's resignation from Meadow Park  
29 and Meadow Park's suspicions regarding who took  
30 the hydromorphone, what, if any, process would  
31 that have prompted?

32 A. That as well would have

1 prompted me to initiate a health inquiry.

2 Q. Based on your experience,  
3 what do you believe the outcome would have  
4 been?

5 A. The results of the health  
6 inquiry would be referred to the inquiry's  
7 complaints and reports committee who would have  
8 considered whether there was a need for an  
9 interim suspension.

10 MR. VAN KRALINGEN: Thank you  
11 kindly for your time today.

12 THE COMMISSIONER: Thank you,  
13 Mr. Van Kralingen.

14 MS. JONES: Madam Commissioner,  
15 we have not yet had an afternoon  
16 recess. I wonder if we might do  
17 that at least briefly for the  
18 sake of the witness.

19 THE COMMISSIONER: Yes, we can  
20 do that. I'm just trying to --  
21 it's quarter after 4.

22 MS. JONES: Yes.

23 THE COMMISSIONER: If we break  
24 and take a normal break, it  
25 would be 4:30. That's often the  
26 time we finish, so perhaps we  
27 should assess where we're at and  
28 decide what's the best way to  
29 proceed.

30 MS. JONES: Sure. Perhaps I'll  
31 consult with Mr. Scott, who's up  
32 next.

1 MR. SCOTT: I probably have only  
2 10 or 15 minutes, Your Honour.  
3 It might take us to the end of  
4 the day.

5 THE COMMISSIONER: In light of  
6 that, perhaps it makes more  
7 sense just to go ahead and  
8 finish at 4:30.

9 MS. JONES: Thank you.

10 THE COMMISSIONER: Do you have a  
11 sense, Ms. Jones, of where  
12 you're at in terms of  
13 cross-examination time, how much  
14 time we'll be in tomorrow?

15 MS. JONES: I expect I'll have  
16 to consult and get updated time,  
17 Madam Commissioner, but I would  
18 expect an hour and half or two  
19 hours, at least.

20 THE COMMISSIONER: It's  
21 essential, yes. So then, in my  
22 view, I think we're better, if  
23 you can stand it for another --

24 THE WITNESS: Yes.

25 THE COMMISSIONER: -- 15 without  
26 a break, I think we're better to  
27 just carry on and finish today  
28 around 4:30-ish and call it a  
29 day. Thank you.

30 CROSS-EXAMINATION BY MR. SCOTT:  
31 Q. Good afternoon, Ms. Coghlan.

32 My name's Paul Scott. I'm a lawyer for one of



1 the other Family Groups. I've got a few  
2 questions for you today. I want to just touch  
3 back on a question that my friend asked you  
4 earlier, fortunately not one of the contentious  
5 questions, one of the easier ones.

6 You'd mentioned that there had  
7 been an increase in the number of reports from  
8 employers?

9 A. Yes.

10 Q. And was it 2017?

11 A. 2018.

12 Q. 2018. And what I'd like to  
13 know is if you have any idea why there has been  
14 an increase?

15 A. It is an assumption that the  
16 awareness of employer reports has risen and  
17 that there is heightened concern, heightened  
18 attention, if you will, to employers'  
19 obligations to make reports to the College.

20 Q. Okay. And is the College  
21 tracking those reports?

22 A. Yes.

23 Q. And I just want to be clear  
24 for myself and for the public that not all  
25 nurses working in Ontario have to be a member  
26 of the Nurses Union, correct?

27 A. That's correct.

28 Q. But all nurses working in the  
29 Province of Ontario have to be members of the  
30 College; is that correct?

31 A. That's correct.

32 Q. And so you told us earlier

1 that the College, your first priority is to  
2 look out for the public; is that correct?

3 A. That is correct.

4 Q. But does the College act as  
5 an advocate for the nurses in Ontario as well?

6 A. No, it does not.

7 Q. So it has no advocacy role  
8 for them?

9 A. No, it does not.

10 Q. Does it provide them with  
11 services; for example, if a nurse is having  
12 difficulties, is there some kind of a number  
13 they can call and get counselling of any  
14 description?

15 A. No, it does not.

16 Q. So that's not something the  
17 College deals with at all for the nurses?

18 A. That's correct.

19 Q. Okay. So we've also talked a  
20 little bit about having employers and  
21 facilities report to the College of incidents  
22 with respect to nurses. We've talked about  
23 that a lot today, correct?

24 A. Yes.

25 Q. Okay. The one thing I do  
26 wonder, though, is does the College have the  
27 authority to request that the facilities or the  
28 employers advise them if there's been any  
29 patient care issues? Do you understand my  
30 question?

31 A. I think I do.

32 Q. Okay, good for you.

1                   A. And absent the legislation  
2 that outlines the criteria for mandatory  
3 reports, the College has no authority to  
4 require.

5                   Q. Right. And that is the crux  
6 of my question. The College can't say to the  
7 facilities: The College demands that you let  
8 us know if you have a problem with a nurse?

9                   A. That's correct. And, in  
10 fact, not all problems with nurses require the  
11 College to intervene. Many issues are  
12 addressed appropriately in the workplace.

13                  Q. Okay. And so you've told me  
14 a moment ago that the College is not an  
15 advocate for the nurses, correct?

16                  A. That's correct.

17                  Q. But does the College educate  
18 itself around the working conditions of the  
19 nurses in the Province of Ontario?

20                  A. The College has awareness by  
21 virtue of its stakeholder collaboration and  
22 engagement. So I mentioned earlier the  
23 Joint Provincial Nursing Committee which brings  
24 together all of the different groups that have  
25 a connection to nursing in the province, and  
26 that's an example of a forum where we would  
27 hear about working conditions.

28                  Q. Okay. And when did that  
29 start, again?

30                  A. Oh, I think it's been going  
31 for over 20 years.

32                  Q. Okay. And so would the

1 College be aware that nurses, RNs specifically,  
2 working in long-term care facilities might be  
3 responsible for a hundred patients on a night  
4 shift?

5 A. We may gather that  
6 information in the course of an investigation,  
7 yes. It may be information that comes to our  
8 attention through our regulatory work.

9 Q. But it wouldn't be something,  
10 it wouldn't be information that you would  
11 gather?

12 A. That's correct.

13 Q. And any kind of information  
14 like that does the College gather on the  
15 nurses' working conditions? I'm thinking about  
16 their wages.

17 A. No.

18 Q. What sort of things they have  
19 to face in a long-term care home in terms of,  
20 you know, stress?

21 A. No.

22 Q. And would that apply to  
23 hospitals and the community as well?

24 A. That's correct. That would  
25 be the role of the Professional Association and  
26 the Union.

27 Q. Okay. But if they're not a  
28 member of the Union, who would be looking at  
29 those items for the nurses?

30 A. The Union and the  
31 professional associations look at system  
32 issues, not just issues related to their

1 individual members.

2 Q. And do they act as an  
3 advocate for the nurses?

4 A. They do.

5 Q. And you told us also that  
6 potential employers have no more information  
7 from the College than the public has; is that  
8 correct?

9 A. That's correct.

10 Q. And does it seem to you that  
11 that may not be the best situation? For this  
12 reason, if I'm an employer and I have to hire a  
13 nurse and then she's going to be exposed to 20,  
14 50, 100 of my patients or my clients, would it  
15 not be good for the employer to have more  
16 information about that person than the general  
17 public so that they can make an informed  
18 decision about hiring?

19 A. Yes, I agree that it would,  
20 and I think there are a variety of sources of  
21 that information, and that's why it is critical  
22 that previous employers provide references and  
23 information that will assist a prospective  
24 employer in making their determination about  
25 whether this individual meets their specific  
26 needs.

27 The employer is in the best  
28 position to assess whether an individual is a  
29 fit with their particular practice environment  
30 and the needs of the residents or clients in  
31 that environment.

32 Q. Do you believe that the

1 College could play a role in that as well,  
2 though?

3 A. I think the College plays  
4 a role in terms of the information that the  
5 College has by virtue of its regulatory  
6 function, and we have endeavored to enhance the  
7 sharing of information with the public, which  
8 includes employers, to ensure that they have  
9 that information.

10 Q. But would you agree with me  
11 that it might be helpful for an employer to be  
12 able to contact the College, give an  
13 undertaking, and be provided with information  
14 that the College has that the public does not?

15 A. What kind of information are  
16 you referring to?

17 Q. Well, for example, no one  
18 would know that Elizabeth Wettlaufer had had an  
19 issue with Geraldton Hospital in 1995, '96,  
20 '97, correct?

21 A. That's correct.

22 Q. And she didn't disclose that  
23 to any of the employers as far as we know.

24 A. Um...

25 Q. But the College had that  
26 information.

27 A. So the prospective employers  
28 for a period of six years had the opportunity  
29 to inquire with the College as to whether there  
30 was information that was publicly available  
31 that would be of assistance to the employer.

32 So that's an example of the

1 College providing information that comes  
2 through its regulatory processes.

3 Q. Yes, I appreciate that, and  
4 you clarified that for us earlier. So you're  
5 in agreement with there being a bit of a sunset  
6 clause on that type of information?

7 A. That was the legislative  
8 regime at the time that has been changed in an  
9 effort to enhance the transparency of  
10 information being (indecipherable).

11 Q. Okay.

12 THE REPORTER: Sorry, I didn't  
13 hear the last part of that.

14 THE COMMISSIONER: She didn't  
15 hear your full answer.

16 MR. SCOTT: I think I hit the  
17 microphone.

18 THE COMMISSIONER: That's part  
19 of the legislative change?

20 THE WITNESS: Yes, that's part  
21 of the legislative change to  
22 enhance transparency of  
23 information, and that means that  
24 that information stays on the  
25 public register indefinitely.

26 BY MR. SCOTT:

27 Q. Thank you. And finally,  
28 you've told us that complaints about a member  
29 must be done in writing; is that correct?

30 A. Yes. Or some documented  
31 version. So for example, we would -- if an  
32 individual required to use an alternate means

1 such as a recording, that would be accepted.

2 Q. Fair enough. And you've  
3 talked a little bit about this practice at the  
4 point of care; do you recall that?

5 A. Yes.

6 Q. And what I took you to mean  
7 was that other health care members of a team in  
8 the facility, they would be working with this  
9 nurse or this person, and they would be in a  
10 better or a more unique position to see what  
11 this nurse is doing or not doing; is that  
12 correct?

13 A. That's correct.

14 Q. And that person would be in a  
15 unique position to provide information to the  
16 College if they think there's a problem; is  
17 that correct?

18 A. It is correct, and members  
19 are encouraged to use the mechanisms within  
20 their workplace. So part of the standards are  
21 to make sure that they do report incidents to  
22 the appropriate role within their setting, so  
23 that may be a nurse manager or a director of  
24 care, and those are the individuals that we  
25 would expect would be making information  
26 available to the College because they are in  
27 the employer role as opposed to a colleague.

28 Where the colleague has a  
29 mandatory report is in relation to sexual  
30 abuse.

31 Q. And we heard about that in  
32 the Facilities phase about management and the



1 nurses, but for lack of a better term, wouldn't  
2 it be advantageous for the other nurse to be  
3 able to cut out the middle man -- in this case,  
4 being the middle man, their employer -- and  
5 just be able to speak directly to the College?

6 A. There's nothing to prevent  
7 them from doing that. It just isn't required.

8 Q. But if they do it via a phone  
9 call, then that won't be investigated, will it?

10 A. It depends what information  
11 is provided.

12 Q. So it would be open to a  
13 nurse who has concerns about a colleague to  
14 call the College directly --

15 A. Yes.

16 Q. -- and provide information to  
17 the College about their concerns --

18 A. Yes.

19 Q. -- and in that case, the  
20 College may take steps to investigate that?

21 A. Yes. And, in fact, we do get  
22 those calls; and, for example, one of the  
23 actions that an intake investigator would take  
24 would be to contact the employer to determine  
25 whether there is additional information that  
26 the employer has that substantiates the  
27 information that's been received through the  
28 phone call.

29 Q. And would the person making  
30 the phone call, would their identity be kept  
31 confidential?

32 A. At that point, yes.

1 Q. Okay.

2 A. Yes. We would make an  
3 inquiry indicating that the College had  
4 received information. We don't disclose at  
5 that point where we've received information  
6 inquiring about the practice of that nurse.

7 Q. And would that information be  
8 stored at the College?

9 A. Yes, it would be. We retain  
10 all information.

11 Q. And so if another complaint  
12 came in about that same nurse, the earlier  
13 complaint could be looked at --

14 A. Absolutely.

15 Q. And do you believe that your  
16 members are aware of that?

17 A. Yes, they are. They are  
18 informed of that.

19 MR. SCOTT: Thank you very much.  
20 Those are my questions.

21 THE WITNESS: Thank you.

22 THE COMMISSIONER: Thank you,  
23 Mr. Scott. Right. I think that  
24 we are finished for the day now.

25 MS. JONES: Thank you,  
26 Commissioner.

27  
28 -- Adjourned at 4:27 p.m.

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REPORTER'S CERTIFICATE

We, DEANA SANTEDICOLA, RPR, CRR, CSR,  
Certified Shorthand Reporter, and OLIVIA  
ARNAUD, CSR, Certified Shorthand Reporter, 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 25th day of July, 2018.



NEESON COURT REPORTING INC.

PER: DEANA SANTEDICOLA, RPR, CRR, CSR  
& OLIVIA ARNAUD, CSR



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