In the Matter Of:

The Long-Term Care Homes Public Inquiry

DAY 4 / VOL 4

June 08, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 4/Volume 4 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 8th day of June, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

REPORTED BY: Deana Santedicola, CSR, CRR, RPR

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

Elizabeth Hewitt, Esq., & Lara Kinkartz, Esq., & Rebecca Jones, Esq., & Megan Stephens, Esq.,	Commission Counsel
Jared B. Schwartz, Esq.,	AdvantAge Ontario
Jane Meadus, Esq.,	Ontario Association of Residents' Councils
David M. Golden, Esq.,	Caressant Care Nursing and Retirement Homes Limited, Caressant Care - Woodstock
Mark Sandler, Esq., & Megan Schwartzentruber, Esq.	College of Nurses
Paul H. Scott, Esq.,	Jon Matheson, Pat Houde, Beverly Bertram
Judith Parker, Esq.,	Her Majesty the Queen in Right of Ontario

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

Alex Van Kralingen, Esq., & Katherine Chau, Esq.,	Arpad Jr. Horvath, Laura Jackson, Don Martin, Andrea Silcox, Adam Silcox-Vanwyk Shannon Lee Emmerton, Jeffrey Millard, Judy Millard, Sandra Lee Millard, Stanley Henry Millard, Susie Horvath
Kate Hughes, Esq., & Nicole Butt, Esq.,	Ontario Nurses Association
Lauren Binhammer, Esq.,	Registered Nurses' Association of Ontario
Jennifer L. McAleer, Esq., & Rachel Laurion, Esq.,	Revera Long-Term Care Inc.
ALSO PRESENT:	
Dr. Fred Mather,	Ontario Long-Term Care Clinicians

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09:13:29 -- Upon commencing at 9:32 a.m.
09:32:03 THE COMMISSIONER: Good morning.
09:32:04 MS. HEWITT: Good morning,
09:32:05 Commissioner.
09:32:05 Just before we go back to
09:32:09 Mrs. Crombez, could we make
09:32:10 Exhibit 16 subject to
09:32:12 redactions. All the documents
09:32:14 in the database have all been
09:32:15 redacted, but there's a couple
09:32:17 of things that we have to do
09:32:18 with the exhibit itself.
09:32:19 THE COMMISSIONER: Yes, no
09:32:20 problem. So Exhibit 16 should
09:32:23 now be marked as subject to
09:32:25 redaction, please, Madam Clerk.
09:32:28 THE COURT CLERK: Noted, thank
09:32:29 you.
09:32:33 HELEN CROMBEZ; Under Prior Oath.
09:32:34 EXAMINATION IN-CHIEF BY MS.
09:32:34 HEWITT (CONT'D):
09:32:37 Q. Good morning, Mrs. Crombez.
09:32:39 A. Would you please call me
09:32:42 Helen. And good morning, Liz.
09:32:44 Q. I'm fine with calling you
09:32:47 Helen.
09:32:47 Yesterday we went through some
09:32:49 preliminary stuff with you, and today we are
09:32:51 going to go through some fairly technical
09:32:53 things in terms of what happened at Caressant
09:32:55 Care regarding medication management, et
09:32:59 cetera, and regarding insulin.

09:33:00 So I'm going to take you through
09:33:02 a lot of the evidence this morning by reading
09:33:06 into the record your affidavit parts, and then
09:33:10 asking you questions based on the information
09:33:12 that you have provided to us.
09:33:14 So first of all, I would like to
09:33:16 turn, Commissioner, to Exhibit 16, the
09:33:20 affidavit. You know what the -- I'm not sure
09:33:27 what the affidavit number is.
09:33:29 A. I have alphabetical numbers.
09:33:32 Am I supposed to look at this or --
09:33:35 Q. No, you can turn to the hard
09:33:37 copy that you have. If you can turn to page
09:33:39 number 8, paragraph number 41. We are just
09:33:44 going to get it --
09:33:46 A. Page number 8?
09:33:50 Q. Down at the bottom, paragraph
09:33:52 41.
09:33:53 A. Uhm-hmm.
09:33:53 Q. All right, we'll just wait
09:33:55 until that gets up on the screen.
09:33:59 A. While we are waiting, I would
09:34:00 like to apologize. I said I was Director of
09:34:03 Nursing yesterday 33 years, and I would like to
09:34:05 correct that. It is 30, as it was in my
09:34:09 document.
09:34:10 Q. Okay, thank you for that
09:34:12 correction. A long time?
09:34:14 A. Yes, a long time.
09:34:16 Q. So can we move to page 8,
09:34:22 paragraph 41, down at the bottom. So your
09:34:30 affidavit indicates, and we'll start at the

09:34:34 1 beginning when a resident first comes in to
09:34:37 2 Caressant Care in relation to medications:
09:34:38 3 "When a resident first enters
09:34:40 4 Caressant Care, a Medication
09:34:43 5 Reconciliation (Med Rec) is
09:34:45 6 done. This is done to ensure
09:34:47 7 that the home had the latest and
09:34:48 8 most complete list of
09:34:49 9 medications used by the resident
09:34:51 10 and their directions. It
09:34:54 11 required at least two sources to
09:34:56 12 complete, e.g. a list of
09:34:58 13 medications and their directions
09:34:59 14 from their previous pharmacy
09:35:01 15 supplier, medications brought in
09:35:05 16 by family on admission, the
09:35:07 17 hospital MAR," and I understand
09:35:09 18 that is Medication
09:35:11 19 Administration Record?
09:35:12 20 A. That's correct:
09:35:16 21 "[...] or hospital discharge
09:35:17 22 summary or the MAR from another
09:35:19 23 long-term care facility. All
09:35:21 24 the medications and their
09:35:22 25 directions are listed on the Med
09:35:25 26 Rec including their source.
09:35:26 27 This was often started the day
09:35:27 28 before admission to facilitate
09:35:29 29 the process. Once the nurse
09:35:30 30 felt it was complete, she would
09:35:31 31 call the Doctor and get the
09:35:33 32 orders. Sometimes, the Doctor

would ask for the form to be faxed to his office. Once the orders were received from the Doctor, the Med Rec was faxed to the pharmacy and a hard copy put in the pharmacy bag to go to the pharmacy. The Pharmacist would sometimes call the nurse to clarify and vice versa."

Who was the pharmacy at Caressant Care?

A. The pharmacy was Medical Pharmacy.

Q. And my understanding from your affidavit is that pharmacy was with Caressant Care for the period that Elizabeth Wettlaufer was there, 2007 to 2014?

A. Yes.

Q. So when a resident enters long-term care, is their medication management required to be taken over by the home?

A. Yes.

Q. And so this process of Medication Reconciliation would be required and is it fair to say it is aimed at switching the resident's medication from wherever they were or whichever pharmacy they were with to the home's pharmacy?

A. That's correct.

Q. In your experience, are most residents that enter long-term care on medications?

09:36:46 A. Yes, most are.
09:36:47 Q. And in your experience, would
09:36:51 they be multiple medications?
09:36:54 A. I would say most residents
09:36:59 had multiple medications.
09:37:00 Q. We heard some testimony
09:37:03 yesterday, or Mr. Sandler indicated that some
09:37:07 testimony may be coming in the days to come as
09:37:10 to the number of medications that a nurse would
09:37:13 give out on any given shift, and the numbers
09:37:17 for each nurse or Registered Nurse or
09:37:21 Registered Practical Nurse is indicated to be
09:37:23 in the hundreds. Is that something that would
09:37:25 be fair to say?
09:37:26 A. That's correct.
09:37:27 Q. And that is on every single
09:37:29 shift?
09:37:29 A. That's correct.
09:37:30 Q. And that would only be --
09:37:32 A. Except night shift.
09:37:33 Q. Except night shift. Yeah,
09:37:37 we'll get into the way that medications work,
09:37:40 but typically, let's take day shift, the
09:37:42 hundreds of medications per shift, correct?
09:37:44 A. Correct.
09:37:45 Q. And then hundreds of
09:37:46 medications for only a portion of the residents
09:37:49 that they are taking care of; is that correct?
09:37:51 A. That's correct.
09:37:52 Q. And in terms of the
09:37:56 medications, would the doctor's orders identify
09:37:59 when those medications are to be given out?

09:38:01 A. The directions could be
09:38:08 specific or it could be left up to the nurse to
09:38:13 decide. We might get an order for BID, which
09:38:18 means twice a day, and the nurse could decide
09:38:23 based on her knowledge if it would be better
09:38:27 given early in the morning, say at 6:00, or
09:38:33 with food at breakfast time, and then the same
09:38:35 with the second dose, when would it be best to
09:38:37 give.
09:38:38 Q. So there is some times when
09:38:40 it would be -- it must be taken at breakfast?
09:38:44 A. Uhm-hmm.
09:38:44 Q. Other times, as I understand
09:38:46 your testimony, it will say bi-daily, but that
09:38:50 is at the discretion of the nurse; is that
09:38:53 correct?
09:38:53 A. Yes, what time to put it,
09:38:55 yes.
09:38:55 Q. But no one else on that shift
09:38:57 would be able to exceed that particular dose?
09:38:59 A. That's correct, without -- if
09:39:02 there needed to be a change to the dosage, then
09:39:05 the doctor should be called.
09:39:08 Q. But other than that, it is
09:39:09 twice daily and that is it?
09:39:11 A. That's right.
09:39:11 Q. And we have heard some
09:39:13 evidence of what is called PRN medication, and
09:39:18 what is that?
09:39:18 A. PRN stands for as needed.
09:39:24 Q. So that would again be up to
09:39:26 the discretion of the nurse?

09:39:27 A. Yes.
09:39:29 Q. And are there limitations on
09:39:30 that discretion in terms of how often you can
09:39:33 exercise it?
09:39:34 A. There may be limitations on
09:39:38 so many tablets per day, or, you know, up to
09:39:42 four times a day, that kind of thing.
09:39:44 Q. And all of that information,
09:39:49 where would that be contained for the nurse
09:39:51 that is going to do any particular medication
09:39:55 distribution in the home?
09:39:55 A. That would be on the doctor's
09:39:57 order sheet.
09:40:00 Q. Would it also be on the
09:40:05 Medication Administration Record?
09:40:06 A. Yes, then it would be
09:40:07 transferred to the Medication Administration
09:40:11 Record.
09:40:11 Q. So when a resident first
09:40:13 comes into long-term care, that whole process
09:40:17 needs to be done in order to get the right
09:40:18 medications at the right time for the right
09:40:22 resident?
09:40:22 A. That's correct.
09:40:23 Q. Okay. Now, my understanding
09:40:25 is that in terms of the medications that may be
09:40:28 given to residents, they could be a combination
09:40:31 of controlled and non-controlled drugs; is that
09:40:34 correct?
09:40:34 A. That's correct.
09:40:35 Q. And when we speak of
09:40:38 controlled drugs, those are narcotics, for

09:40:41 example?
09:40:41 A. Narcotics and Ativan were
09:40:44 considered the controlled drugs.
09:40:45 Q. And we heard earlier
09:40:47 testimony, is Ativan also known as Lorazepam?
09:40:52 A. That's correct.
09:40:52 Q. And what would be an example
09:40:55 of a non-controlled drug?
09:40:56 A. Lasix, Tylenol, any laxative.
09:41:06 Q. And just for the benefit of
09:41:09 those that aren't in the nurse's profession,
09:41:11 what would Lasix be used for?
09:41:14 A. Fluid accumulation.
09:41:20 Q. So you are trying to get the
09:41:22 fluid out of the resident?
09:41:22 A. Yes, it is usually
09:41:24 demonstrated in the lower legs, but it can, you
09:41:28 know, be around the heart as well.
09:41:30 Q. And the medications coming in
09:41:33 could be in pill form or injectable forms of
09:41:37 both controlled and non-controlled drugs; is
09:41:42 that correct?
09:41:42 A. Correct.
09:41:42 Q. And one injectable form of a
09:41:45 non-controlled drug is insulin?
09:41:47 A. That's correct.
09:41:47 Q. Now, once all of the
09:41:54 medications are reconciled, what happens next
09:41:58 in the admission process? So you have now got
09:42:02 the right medications ordered with the
09:42:04 pharmacy.
09:42:05 A. The medications would come

09:42:09 1 from pharmacy and they would be put in the
09:42:14 2 appropriate slot or box in the medication cart
09:42:21 3 for that particular resident.
09:42:23 4 Q. So let's just stop there for
09:42:26 5 a moment. In terms of non-controlled drugs
09:42:30 6 that are in pill form, how do they come for
09:42:35 7 each resident?
09:42:36 8 A. Well, in the early days they
09:42:37 9 came in cards and it was a monthly supply, and
09:42:40 10 then the pharmacy changed that to cycle-fill,
09:42:46 11 which were medications packaged per time in a
09:42:54 12 little plastic sleeve and they were attached, a
09:43:01 13 whole roll of medications, and they would have
09:43:04 14 the 8 o'clock medications, the 12 o'clock
09:43:06 15 medications all in the roll.
09:43:10 16 And the nurse, during
09:43:11 17 administration, would, you know, tear off the
09:43:13 18 pouches that she needed for that time and
09:43:17 19 administer it to the resident.
09:43:18 20 Q. And that is what you refer to
09:43:21 21 as a cycle strip?
09:43:23 22 A. Yes, a strip pack.
09:43:26 23 Q. How many days' supplies of a
09:43:30 24 cycle strip are delivered at a time?
09:43:33 25 A. A week's supply.
09:43:34 26 Q. Are those on automatic
09:43:40 27 reorder or do they have to be -- every pill
09:43:42 28 have to be reordered every week?
09:43:44 29 A. It would be a reorder, and it
09:43:47 30 was like a little tab, I believe, on the
09:43:48 31 computer that you touched.
09:43:51 32 Q. Okay. Now, we are going to

talk about the delivery of medications in a moment, and for your benefit as well, Commissioner, we are going to deal with insulin on its own. We are just doing generalities right now for medication management and administration.

So we'll talk about delivery in a moment, but once they come to the home, you indicated that the cycle strips, for instance, are put in the medication cart?

A. That's correct.

Q. And yesterday I believe you testified that those carts are locked and only registered staff have the keys?

A. That's correct.

Q. And that those carts, if they are not being used, are locked then in the medication rooms?

A. Yes.

Q. Now, does the same key open both the medication cart and the medication room?

A. No, the medication room was a separate key and each cart had a separate key.

Q. And those, I think you said, go right into the medication cart, the cycle strips?

A. Yes, they do.

Q. And where in the medication cart would those be located?

A. Well, there were probably about five drawers in a medication cart, and

09:45:07 1 the first drawer too were narrow, and, you
09:45:16 2 know, they would keep some of the government
09:45:17 3 stock in there, like Tylenol 500. They
09:45:23 4 might -- it has been awhile since I have looked
09:45:29 5 inside a medication cart.
09:45:32 6 The larger bins underneath would
09:45:40 7 hold the strip packs. They were a little bit
09:45:42 8 deeper and little boxes fit in there. And the
09:45:50 9 strips would go inside those little boxes for
09:45:53 10 each resident.
09:45:53 11 Q. And is the box in this drawer
09:45:57 12 in the medication cart, whichever drawer it is,
09:45:59 13 and we'll have registered staff that will tell
09:46:02 14 us where in particular, but are there any
09:46:06 15 identifiers on those boxes?
09:46:08 16 A. They have a name for each
09:46:10 17 resident. Each resident was identified by name
09:46:12 18 on the box.
09:46:16 19 Q. And the cycle strip itself,
09:46:17 20 does it have any identifiers on it?
09:46:21 21 A. Yes, it would have the
09:46:24 22 resident's name, the doctor's name, the name of
09:46:29 23 the medications were all underneath, so if
09:46:32 24 there were six medications in that little
09:46:36 25 pouch, they would be all listed with their
09:46:39 26 strength and the directions.
09:46:41 27 Q. All right. And those six
09:46:43 28 medications would be given at one time because
09:46:45 29 they are in one cycle strip?
09:46:47 30 A. Uhm-hmm.
09:46:47 31 Q. One of the packages.
09:46:49 32 A. And one resident might have,

09:46:51 you know, two or three of those pouches.
09:46:54 Q. And per medication pass or
09:46:59 two or three of those pouches because they are
09:47:01 getting medications in the morning and at lunch
09:47:04 and then in the evening?
09:47:05 A. No, for the one pass in the
09:47:07 morning.
09:47:07 Q. And what would determine
09:47:08 whether they have more than one of the little
09:47:10 packages?
09:47:11 A. Just what the doctor ordered.
09:47:14 Q. Right. So would that be just
09:47:15 a volume issue as to how much you can fit in
09:47:19 one of those?
09:47:19 A. Uhm-hmm.
09:47:20 Q. Sorry?
09:47:20 A. Yes, you know, there was only
09:47:22 so much room in the pouch, and there was only
09:47:25 so much room to write or print on the pouches,
09:47:30 so...
09:47:30 Q. So the medications are
09:47:32 ordered. They come in and, as I said, we'll
09:47:36 deal with it coming in in a minute, but the
09:47:38 strip pills are put in a bin with the
09:47:41 resident's name in a medication cart that is
09:47:43 locked; have I got that correct?
09:47:44 A. That's correct.
09:47:45 Q. And please tell me, because
09:47:46 it is your profession, not mine, if I don't
09:47:49 have that -- if I'm not summarizing your
09:47:52 evidence correctly.
09:47:54 Now, how about narcotics or

09:47:57 controlled drugs. Do those come in those
09:47:59 little type packages?
09:48:00 A. No, they stayed in the carded
09:48:04 system, so we would have a month's supply of
09:48:07 those. And the card would hold 31 tablets, and
09:48:17 you would start with number 31 on the top
09:48:21 left-hand side and work your way down the
09:48:24 numbers until the card was empty.
09:48:26 Q. Let me stop you there,
09:48:28 because I am too old and I need visual aids, so
09:48:34 I'm going to take you to a document that is
09:48:36 actually in your exhibit, and it is tab number
09:48:39 GG and it is document number 16910. And we are
09:48:56 actually going to look at a medication error
09:48:57 that was attributed to Elizabeth Wettlaufer and
09:49:01 just see if we can talk about two things at
09:49:08 once, basically.
09:49:08 So if you are at tab GG,
09:49:11 document 16910, all right, first of all, can
09:49:30 you identify what is this document?
09:49:32 A. This is a Caressant Care
09:49:36 internal resident Incident Report.
09:49:40 Q. What would it be used for?
09:49:41 A. It was filled out when there
09:49:46 was an incident regarding a resident, whether
09:49:50 it was a medication error or a fall.
09:49:54 Q. And on this particular form,
09:49:57 at the top of the page it says date and time of
09:50:01 incident, March 23, 2008, 20:45, so that would
09:50:09 be 8:45 in the evening; am I reading that
09:50:12 right?
09:50:13 A. Actually 6:25 -- oh, up here,

09:50:15 sorry, yes, 8:45, right.
09:50:16 Q. Would that be the evening
09:50:18 shift?
09:50:22 A. Yes, it would be, uhm-hmm.
09:50:23 Q. And we have the next
09:50:24 identifier, the name of the person who
09:50:26 discovered incident, and the individuals are
09:50:27 named there?
09:50:28 A. Yes, they were doing the
09:50:30 narcotic count, I believe.
09:50:31 Q. And then "type of incident,"
09:50:34 it has a dot and "medication error." Was this
09:50:38 a computerized system?
09:50:42 A. How do you mean a
09:50:43 computerized system?
09:50:44 Q. Was it online? Did they fill
09:50:45 it out online and push --
09:50:47 A. Yes, it was part of our Point
09:50:49 Click Care system, yes.
09:50:50 Q. And down under "Description,"
09:50:53 "Brief description of incident":
09:50:56 "During narcotic count on March
09:50:59 23, '08 HS Tylenol #3 signed for
09:51:04 as given but not given."
09:51:05 Just for the benefit of myself
09:51:07 and those watching, what do the initials "HS"
09:51:12 stand for.
09:51:13 A. Bedtime.
09:51:14 Q. Bedtime, thank you. And
09:51:16 Tylenol number 3, would that be a controlled
09:51:18 drug?
09:51:19 A. Yes, it would be.

09:51:20 Q. And --
09:51:28 MR. SANDLER: Sorry, I misheard
09:51:30 what HS stands for, sorry.
09:51:33 MS. HEWITT: Bedtime.
09:51:34 MR. SANDLER: Bedtime, thank
09:51:35 you.
09:51:36 BY MS. HEWITT:
09:51:38 Q. And then down at the bottom
09:51:40 right-hand side, and I'm not going to go to the
09:51:42 top yet, but bottom right-hand side is "Please
09:51:45 file for Bethe." Is it your understanding that
09:51:47 this medication incident involved Ms.
09:51:51 Wettlaufer?
09:51:51 A. Yes, I do.
09:51:52 Q. Now, I said I was going to do
09:51:55 some education on both things at once, so if I
09:51:58 can have you turn to document 16911. It is in
09:52:03 that same tab, Commissioner, just the next
09:52:06 document.
09:52:12 A. I don't have the next
09:52:13 document.
09:52:14 THE COMMISSIONER: Behind the
09:52:15 blue --
09:52:16 BY MS. HEWITT:
09:52:16 Q. There should be a blue --
09:52:17 A. Oh, a blue divider sheet?
09:52:19 Sorry, yes, yes, this is it.
09:52:20 Q. Now, you were -- before I
09:52:24 took you to that first document, you were
09:52:25 talking about a narcotic card and you started
09:52:27 to talk about number 31 down, so this document,
09:52:35 this copy of something that we are looking at,

09:52:36 what is this?
09:52:38 A. This is a medication card for
09:52:42 Tylenol number 3.
09:52:45 Q. And is this what you were
09:52:46 talking about, the narcotic card that would be
09:52:48 delivered for each resident?
09:52:50 A. That's right, if it were
09:52:51 ordered, this is how it would come.
09:52:53 Q. All right.
09:52:55 A. If it were in pill form.
09:52:57 Q. Right, if it was injectable,
09:52:59 it would be a different form. But the narcotic
09:53:02 card that you are talking about, this would
09:53:05 identify the resident at the top, does it?
09:53:09 A. That's correct.
09:53:10 Q. And what other information at
09:53:12 the top does this particular copy of this card
09:53:16 give us?
09:53:17 A. Well, it gives us the
09:53:20 pharmacy supplier, the treatment number, or
09:53:28 prescription number, rather, that this
09:53:30 medication belongs at Caressant Care Nursing
09:53:38 Home, on south, I believe.
09:53:41 Q. Okay.
09:53:41 A. And the directions are there,
09:53:44 "1 to 2 tablets by mouth 4 times daily," and
09:53:48 then it gives the generic name and then it
09:53:53 gives a description of what the pill actually
09:53:55 looks like and then the doctor who ordered it.
09:53:58 Q. And by the description, you
09:54:02 are talking about "Tylenol No. 3 round white
09:54:08 tec RPH"?

09:54:09 A. Yes.
09:54:10 Q. What does "RPH" mean?
09:54:13 A. Sorry?
09:54:14 Q. The description, number 3, is
09:54:16 that RND, is that round?
09:54:18 A. Yes, Tylenol number 3 round,
09:54:20 it is a white round tablet. I am not sure what
09:54:23 the "Tec RPH," that might be some printing on
09:54:28 the other side of the tablet, I'm not sure.
09:54:30 Q. All right, but the nurse
09:54:32 should be able to determine am I giving a white
09:54:34 round pill or am I giving an oval pink pill by
09:54:38 that description?
09:54:38 A. That's correct.
09:54:39 Q. Now, can you tell by looking
09:54:41 at this card -- we notice that the medication
09:54:44 incident was that a drug wasn't given. Can you
09:54:46 tell by looking at this card if that was the
09:54:48 case?
09:54:49 A. Yes, there appears to be a
09:54:52 round white tablet in pocket number 1.
09:54:57 Q. Now, you started this morning
09:55:00 when you were talking about the card, you said
09:55:01 you start at 31, and so I notice on this card
09:55:04 at the very top, it is actually nice printing
09:55:10 that I can see, it says "start"; is that what
09:55:13 you were talking about?
09:55:14 A. That's correct.
09:55:14 Q. So the nurse starts at pill
09:55:18 number 31 and goes down to pill number 1?
09:55:21 A. That's correct.
09:55:21 Q. And then the right-hand side

09:55:24 1 of this sheet has five different pills that are
09:55:29 2 in a black box that says "reorder," and what
09:55:33 3 does that signify?
09:55:34 4 A. Well, when you got to the
09:55:36 5 fifth tablet, it was time to reorder this
09:55:39 6 medication from pharmacy. So there would be a
09:55:43 7 pull tab. This is, you know, the carded
09:55:51 8 system, so you would pull the tab and put that
09:55:53 9 in the pharmacy reorder book.
09:55:55 10 Q. Now, at the top there is
09:55:59 11 handwriting, "2000," or "2000," I'm not sure
09:56:05 12 what that means?
09:56:06 13 A. That stands for 8 o'clock,
09:56:07 14 which was the average bedtime for the bedtime
09:56:10 15 pass.
09:56:11 16 Q. Okay. And so if I can now
09:56:17 17 have you turn to document 16912, the same --
09:56:28 18 sorry, Commissioner, same exhibit, just the
09:56:31 19 next document.
09:56:32 20 Now, what is this particular
09:56:36 21 document, Helen?
09:56:38 22 A. This is the Individual
09:56:42 23 Narcotic Medication Record.
09:56:45 24 Q. And is this the record that
09:56:49 25 is associated with the copy of the card we were
09:56:52 26 just looking at?
09:56:53 27 A. That's correct. The nurse
09:56:55 28 would pop the pill and then sign that sheet as
09:57:03 29 taken it out and that there is whatever number
09:57:05 30 left.
09:57:05 31 Q. All right. So if we start at
09:57:07 32 the top, there is the date, and is that the

09:57:10 1 date the pill is given?
09:57:11 2 A. That's correct.
09:57:11 3 Q. And the "time," what does
09:57:14 4 that reference?
09:57:14 5 A. The time that the medication
09:57:16 6 was given.
09:57:17 7 Q. All right, and "31"?
09:57:20 8 A. The number of tablets
09:57:21 9 remaining in the card.
09:57:23 10 Q. All right. Is it the number
09:57:26 11 of tablets remaining or is that the number of
09:57:28 12 the tab --
09:57:32 13 A. That is the tablet that was
09:57:33 14 given.
09:57:34 15 Q. Okay.
09:57:34 16 A. And then once -- you know,
09:57:37 17 these are all circled now, but that 30 would
09:57:41 18 not have a circle so then you would know there
09:57:43 19 was supposed to be 30 tablets left in the card.
09:57:46 20 Q. All right. So if I can just
09:57:47 21 summarize, it has 31 under "blister number,"
09:57:51 22 and then it has an RN or an RPN's name, so does
09:57:56 23 that signify that that particular nurse took
09:58:00 24 out pill number 31 and gave it to the resident?
09:58:03 25 A. That's correct.
09:58:03 26 Q. And then if we go over, it
09:58:07 27 identifies the "amount given"?
09:58:10 28 A. That's correct.
09:58:11 29 Q. And is that a "T"?
09:58:14 30 A. It is actually a "1." I
09:58:20 31 don't know if it is Latin. I think it is
09:58:22 32 Latin, and it is the way we were trained years

09:58:26 ago to document medication.
09:58:28 Q. Oh.
09:58:29 A. If there were two tablets, it
09:58:32 would have two little lines and two little
09:58:34 dots.
09:58:34 Q. Are you still using that
09:58:35 system today? This is 2000 -- sorry, this was
09:58:41 quite some time ago, 2008. Is that still the
09:58:45 system, to the best of your knowledge?
09:58:46 A. As far as I know.
09:58:47 Q. Okay. And then if we go over
09:58:49 to "amount wasted," what would that -- there is
09:58:52 nothing here, but what would that generally
09:58:54 signify?
09:58:54 A. Well, if you dropped it on
09:58:58 the floor, for instance, or if, you know, the
09:59:01 resident didn't want it for some reason.
09:59:08 Q. And then the final column is
09:59:14 "quantity/balance," and that is where it says
09:59:18 there is 30 left; is that correct?
09:59:19 A. Yeah, that number should
09:59:21 match, you know, what isn't circled on your
09:59:25 left-hand column.
09:59:26 Q. All right. I won't take you
09:59:28 back, so we don't flip back and forth, but
09:59:33 document number 16911, the pill that you
09:59:37 indicated is found in blister number 1. So can
09:59:42 you tell us if by looking at this Individual
09:59:45 Narcotic Medication Record you can identify who
09:59:49 signed the pill as being given but then others
09:59:55 discovered it was still in the pack?
09:59:56 A. It was Bethe Wettlaufer that

failed to give this medication.
Q. And just for our benefit, can you tell us how you determined that?
A. That is her signature.
Q. And is that at the very bottom?
A. That is at the very bottom, yes.
Q. So the bottom, we know from your testimony that she should have been taking out of blister 1 that pill and she would only sign this document if it was given; is that correct?
A. That's correct.
Q. And so --
A. She wasn't following proper process.
Q. All right, and that was brought to your attention, I assume?
A. That's correct.
Q. All right. I do want to take you, just to round out this particular incident so we won't have to go back potentially later, if I can take you back in that same tab to the first document and that is document 16910.
Now, whose handwriting appears on the right-hand side of that document?
A. That is my handwriting.
Q. And could you read it for us?
A. I determined that it was Bethe's mistake, so I had written here:
"Speak to Bethe."

10:01:28 1 And then:
10:01:30 2 "Spoke to Bethe Mar. 28/08 at
10:01:34 3 18:25. I pointed out error.
10:01:36 4 She said she was in a hurry and
10:01:39 5 didn't follow her usual process.
10:01:42 6 I asked her to give meds
10:01:45 7 correctly and sign as she went,
10:01:48 8 even if it took her past the end
10:01:50 9 of her shift and to ask for
10:01:53 10 [overtime]."
10:01:59 11 Q. And is that how you handled
10:02:00 12 this particular incident with Ms. Wettlaufer on
10:02:02 13 March the 23rd, 2008?
10:02:04 14 A. That's correct.
10:02:10 15 Q. So she wasn't disciplined for
10:02:11 16 this particular incident?
10:02:12 17 A. No, this would be considered
10:02:13 18 a counselling.
10:02:14 19 Q. All right. Now, can you
10:02:16 20 explain for the Commissioner what is the home's
10:02:18 21 philosophy, if any, around how to handle
10:02:21 22 medication errors that nurses may make?
10:02:24 23 A. We didn't discipline for
10:02:30 24 medication errors, and this was a philosophy
10:02:35 25 brought to us by the pharmacy that nurses were
10:02:41 26 under-reporting medication errors and they felt
10:02:45 27 that it would be best practice to remove the
10:02:49 28 discipline from medication incidents so that
10:02:54 29 nurses would feel comfortable reporting
10:02:58 30 themselves and reporting each other so that
10:03:02 31 corrections could be made more quickly, if
10:03:04 32 necessary.

10:03:05 Q. And is that philosophy
10:03:09 accepted within the profession, from your
10:03:12 experience?
10:03:12 A. Yes, it is.
10:03:12 Q. And that type of a situation
10:03:16 where you attempt to not discipline for med
10:03:20 errors, is that a positive, a negative, or
10:03:23 neutral change, from your perspective?
10:03:25 A. I thought it was a positive
10:03:27 change. I wanted nurses to report so that if
10:03:33 it was something serious, it could be
10:03:36 corrected.
10:03:36 Q. And what would happen if a
10:03:39 nurse didn't come forward to report a serious
10:03:43 error she had made, or he, and realized but
10:03:47 didn't come forward? What is the potential
10:03:51 ramifications of that?
10:03:54 A. Well, I could use an example
10:03:56 from a hospital setting that I was aware of.
10:03:58 Q. As long as -- we are fine
10:04:00 with any examples, as long as no patients'
10:04:02 names are used.
10:04:03 A. I don't know any of the
10:04:04 people's names, but it was regarding insulin as
10:04:10 well and the nurse gave 1,000 units in error
10:04:17 and realized it almost immediately. There was
10:04:20 an insulin specialist in the hospital. She
10:04:25 quickly notified her superior and this doctor
10:04:29 was brought to the floor, and the patient did
10:04:35 not -- the patient didn't die, because of her
10:04:39 action.
10:04:39 Q. All right.

10:04:42 A. And she was not disciplined.
10:04:43 Q. Thank you. So we have looked
10:04:51 at the narcotic card and a medication incident
10:04:56 all together, so we can accomplish a couple of
10:04:59 things at once.
10:05:00 But I want to continue with our
10:05:03 discussion on medication management, so I want
10:05:05 to go back to your affidavit and, in
10:05:10 particular, paragraph 42. And just quickly,
10:05:44 you indicate:
10:05:45 "Reordering of medication is
10:05:47 done automatically through the
10:05:48 cycle system. We have a weekly
10:05:50 supply of medications for each
10:05:51 resident and they come at a
10:05:53 scheduled time and a scheduled
10:05:54 day for each floor. If there
10:05:56 are changes to a resident's
10:05:57 medication, that order is faxed
10:05:59 to pharmacy at the time of
10:06:00 change."
10:06:03 And then paragraph 44:
10:06:05 "When received, medications are
10:06:06 scanned in and checked by the
10:06:08 night nurse. The medications
10:06:10 come two days early so that the
10:06:12 staff have two nights to check
10:06:14 the medications and if there's
10:06:16 any discrepancies those are
10:06:18 hopefully corrected before the
10:06:19 cycle goes into effect."
10:06:23 So are they delivered to the

10:06:25 night nurse or are they delivered on a
10:06:27 different shift?
10:06:28 A. They are delivered on the
10:06:30 evening shift around suppertime, which was 5
10:06:34 o'clock.
10:06:34 Q. And when they are delivered,
10:06:40 in general how were they packaged? How do they
10:06:45 come into the home?
10:06:46 A. If it was the cycle-fill that
10:06:47 they were receiving, it would be in a tote.
10:06:49 Q. And that is all those little
10:06:52 strip medications?
10:06:54 A. Yes.
10:06:54 Q. And narcotics?
10:06:57 A. They would be packaged
10:06:59 separately.
10:07:00 Q. Would they come in the same
10:07:05 shipment?
10:07:05 A. At the same time, but in a
10:07:11 different bag.
10:07:12 Q. All right.
10:07:14 A. I believe.
10:07:15 Q. Now, you indicate that the
10:07:21 cycle strips -- sorry, you indicate that they
10:07:25 come in and they are accepted on the afternoon
10:07:28 shift, and then generally speaking it is the
10:07:31 night shift that enters them and reconciles
10:07:33 them; is that correct?
10:07:34 A. That's correct.
10:07:36 Q. So until the night nurse gets
10:07:38 to those medications that are in the tote or
10:07:41 are separately stored or separately packaged,

10:07:45 1 where are they stored?
10:07:46 2 A. In the med room.
10:07:48 3 Q. And do the narcotics stay in
10:07:57 4 the packages in the med room as well?
10:07:59 5 A. No, the nurse was to pull
10:08:00 6 them out and put them in the narcotic bin, and
10:08:10 7 she had a form to sign as well that she
10:08:13 8 received the narcotics and that would go back
10:08:16 9 to pharmacy.
10:08:16 10 Q. Okay.
10:08:19 11 A. And that, you know, happens.
10:08:21 12 That form was an extra form. That wasn't
10:08:24 13 always there, but that developed over time.
10:08:28 14 Q. So for the cycle strips, they
10:08:30 15 would come and be in the locked med room until
10:08:32 16 they are put into the cart by the night nurse;
10:08:35 17 is that your evidence?
10:08:36 18 A. Sorry, would you repeat that?
10:08:38 19 Q. The tote with all the cycle
10:08:40 20 medications would be locked in the medication
10:08:44 21 room until the night nurse reconciles them and
10:08:47 22 puts them in the medication cart?
10:08:48 23 A. Usually. If it was a good
10:08:51 24 evening, then the evening nurse might start.
10:08:54 25 Q. Okay. But the narcotics were
10:08:55 26 put right away in the narcotic bin in the
10:08:58 27 medication cart?
10:08:59 28 A. Yes, that's correct.
10:09:00 29 Q. The narcotic bin in the
10:09:01 30 medication cart -- sorry. Is it not a bin? It
10:09:09 31 is a drawer, right?
10:09:10 32 Sorry, so the narcotics come

into the home and I think you indicated that they were to be put right away into the medication cart; is that correct?

A. That's correct. It might not be in the right cart, but the nurse who took the medications would just put them in her cart and then look at that, because they were busy giving their supper medications and then they would, you know, distribute them when that pass was over.

Q. Okay. And so they would, as narcotics, always be locked up upon receipt?

A. They were supposed to be, yes.

Q. And then when that particular afternoon nurse or evening nurse and/or night nurse reconciled the narcotics, I think you indicated there was a separate step and they would have to fax back to the pharmacy what they had received; is that correct?

A. Fax back or it was a sheet that the pharmacy driver took back.

Q. If they were able to do it right then? Or did they do it right then, at least reconcile what they received?

A. I think they did it right then to make sure -- the pharmacy wanted to know that we had received the medications, that it hadn't been diverted en route.

Q. Thank you. So when the nurses are giving out their medications, what is that called?

10:10:44 A. Administration.
10:10:46 Q. And we have heard the term or
10:10:50 the term is in our Overview Report of
10:10:54 "medication pass"; what is that?
10:10:55 A. That is considered the
10:11:01 administration of, say, the 8 o'clock
10:11:02 medications to the residents.
10:11:05 Q. So when they say that a nurse
10:11:07 does a "medication pass," is that where she is
10:11:09 delivering all of those 8 o'clock medications?
10:11:12 A. The medications, that's
10:11:14 correct.
10:11:14 Q. And typically, in a day, or
10:11:21 in a shift, I should say, on the day shift how
10:11:24 many medication passes would be done?
10:11:26 A. Well, there would be the 8
10:11:29 o'clock med pass.
10:11:32 Q. Is that 8 o'clock in the
10:11:33 morning?
10:11:33 A. 8 o'clock in the morning.
10:11:35 Q. Uhm-hmm.
10:11:36 A. There would be a 10 o'clock
10:11:37 medication pass, a 12 o'clock medication pass.
10:11:49 There might be a few medications at 2 o'clock.
10:11:55 And that would be it for the day shift.
10:11:57 Q. Okay.
10:11:58 A. And there might be some
10:11:59 things given at, you know, 7:30 or 8:30,
10:12:07 depending on what the medication was.
10:12:10 Q. And are any of these passes
10:12:14 more intense than others, involve more
10:12:16 medications to be given out than others?

10:12:19 A. The most intensive pass was
10:12:21 the morning pass. The daily medications were
10:12:26 usually given with breakfast.
10:12:30 Q. And you indicate in your
10:12:40 affidavit at paragraph 48:
10:12:49 "When nurses would give
10:12:50 medication, they would consider
10:12:52 a number of 'rights' such as
10:12:54 right dosage, right time, right
10:12:56 route, right medication, right
10:12:59 resident, right to refuse, right
10:13:02 documentation, right effect."
10:13:07 So right doses and right time I
10:13:09 think is fairly clear, but what do you mean by
10:13:12 "right route"?
10:13:13 A. If it were -- if it was to be
10:13:17 given orally, for instance, or subcutaneously
10:13:22 or intramuscularly, or eye drops would be right
10:13:29 eye or left eye.
10:13:31 Q. Okay, and "right to refuse,"
10:13:32 what does that mean?
10:13:33 A. The resident has the right to
10:13:36 refuse, you know, the treatment and medications
10:13:39 was considered part of that.
10:13:41 Q. And if --
10:13:43 A. But we didn't give up easily.
10:13:45 We tried, you know, two or three times.
10:13:47 Q. To convince the resident, is
10:13:49 that what you mean?
10:13:50 A. To give the resident their
10:13:52 medications, gentle encouragement, you know, we
10:13:56 wanted them to stay as healthy as possible and

10:13:59 1 believed that the medications were there for a
10:14:01 2 purpose.
10:14:01 3 Q. And if a resident has a
10:14:07 4 substitute decision-maker, are you entitled --
10:14:11 5 sorry, if the substitute decision-maker says,
10:14:15 6 no, I want my loved one to get a pill, are you
10:14:18 7 entitled to force that resident to take the
10:14:21 8 pill?
10:14:21 9 A. No, we would never force
10:14:23 10 anyone.
10:14:23 11 Q. So if a resident was on
10:14:25 12 medication that would assist in behaviours, et
10:14:28 13 cetera, but didn't want to take it, did you
10:14:30 14 have a route to force that resident to take
10:14:32 15 that medication?
10:14:33 16 A. Would you repeat that,
10:14:37 17 please?
10:14:37 18 Q. So if a resident was on a
10:14:40 19 medication to help with behaviours but refused
10:14:43 20 to take it, I don't want it, did you have an
10:14:46 21 ability, even with those residents, to force
10:14:48 22 them to take pills that would assist with
10:14:50 23 behaviours?
10:14:51 24 A. No, we weren't to force. You
10:14:53 25 know, we would encourage or try and talk them
10:14:56 26 into it, but we wouldn't force.
10:14:57 27 Q. And I just want to talk a bit
10:15:02 28 about the right resident, because we are all
10:15:05 29 getting educated about long-term care at the
10:15:07 30 same particular time.
10:15:09 31 But in a hospital, is it fair to
10:15:13 32 say that when you go to give medications out,

10:15:17 1 the patient is generally in his or her bed in a
10:15:20 2 room?
10:15:20 3 A. That's correct.
10:15:22 4 Q. Now, at long-term care on
10:15:24 5 these medication passes that you are talking
10:15:26 6 about, 8:00 a.m., 10:00 a.m., 12:00 and 2
10:15:31 7 o'clock, and maybe some others, do the
10:15:34 8 residents all go back to their room and
10:15:39 9 medications are given out, or how does that
10:15:41 10 happen?
10:15:42 11 A. Well, the resident may be out
10:15:43 12 of their room. They may be in the lounge or
10:15:46 13 the activity room or in the restorative care
10:15:50 14 room. We had a picture of the resident on the
10:15:56 15 Medication Administration Record to help with
10:15:58 16 identification, and if you weren't sure of who
10:16:00 17 the resident was, the nurse was to ask, can you
10:16:05 18 tell me your name?
10:16:06 19 Q. And what if the resident
10:16:08 20 wasn't able to respond as to what his or her
10:16:11 21 name was?
10:16:11 22 A. Then you would ask a staff
10:16:13 23 member, do you know the name of this resident?
10:16:17 24 Q. And so if there is -- on the
10:16:24 25 day shift, how many, in general, residents
10:16:30 26 would one RN or one RPN be delivering
10:16:33 27 medications to?
10:16:34 28 A. Normally between 30 to 35.
10:16:38 29 Q. And those 30 to 35 residents
10:16:43 30 could be located anywhere within the home, if
10:16:47 31 they had access and mobility?
10:16:48 32 A. Yes. Now, when the pass was

10:16:53 1 at 8 o'clock, most were in the dining room and
10:16:57 2 they did have a seating plan, you know, to help
10:17:00 3 with identification.
10:17:01 4 Q. Were residents required to
10:17:04 5 sit or stay seated in the dining room until
10:17:07 6 they got their medication or were they free to
10:17:10 7 wander?
10:17:11 8 A. No, they were free to go, and
10:17:12 9 if they were someone that liked to leave early,
10:17:18 10 the nurse would try and give -- the nurse would
10:17:21 11 get to know that and try and give their
10:17:23 12 medication before they left the dining room.
10:17:25 13 Q. So all of those medications,
10:17:35 14 however, would still have to be delivered.
10:17:37 15 They would have to find at some point in time
10:17:39 16 around that particular time every one of those
10:17:41 17 32 residents, if all 32 were getting
10:17:44 18 medications?
10:17:44 19 A. That's correct.
10:17:45 20 Q. And while they are doing
10:17:57 21 that, while they are doing their medication
10:17:59 22 pass, are they free from interruption? Is
10:18:02 23 somebody else responding to any issues?
10:18:04 24 A. No, they had interruptions.
10:18:11 25 They might get a phone call. They might
10:18:16 26 respond to a resident who is falling or choking
10:18:21 27 or a family member might come up to them and
10:18:30 28 say, I would like to take my mom out for the
10:18:32 29 day, that kind of thing.
10:18:35 30 Q. And if something like that
10:18:39 31 happened, speaking from experience, family
10:18:43 32 members can be a little pushy, but if something

like that happened, would the nurse generally respond to what the family member wanted?

A. It depended on what the -- if it was the family member, she would maybe direct the family member to the ward clerk to assist. But if, you know, she needed to take medication with her, then the nurse would have to stop what she was doing and help with that, or ask her if she minded waiting, you know, 15 minutes, that kind of thing.

Q. All right. So we have talked about the ordering, the initial reconciliation of drugs when a resident comes into the home, and we have talked about delivery, storage in the medication cart, medication passes.

And I just want to talk to you then about the end of the day, after all the passes are done. At paragraph 49 of your affidavit it talks about:

"Nursing staff complete the controlled substance count every shift. They are to remove the narcotics from the locked bin in the lowest drawer of the medication cart and put it in a cardboard box and then they are to go to a counter or a table and both nurses are to look at each resident's narcotic card, the narcotic count sheet [...]"

Is that what we referred to later where it goes 31 down to 1?

10:20:22 A. That's correct.
10:20:24 Q. "[...] and both nurses are to
10:20:26 watch what the recording nurse
10:20:27 writes down to make sure
10:20:28 everything is accurate."
10:20:30 So as I understand your evidence
10:20:31 there, these counts are done at every shift
10:20:33 change?
10:20:33 A. That's correct.
10:20:34 Q. And if we look at Caressant
10:20:40 Care, can you just remind the Commissioner as
10:20:42 to what those shifts were?
10:20:47 A. The day shift was normally
10:20:48 7:00 to 3:00, but we, you know, did have 6:30
10:20:53 to 2:30 at times.
10:20:56 Q. Just generally speaking, 7:00
10:20:57 to 3:00 days.
10:21:01 A. 7:00 to 3:00, 3:00 to 11:00
10:21:04 and 11:00 to 7:00.
10:21:05 Q. So 3:00 to 11:00 would be
10:21:07 what would be called evening shift in the
10:21:08 record here?
10:21:09 A. That's correct.
10:21:09 Q. And 11:00 to 7:00 the night
10:21:12 shift?
10:21:12 A. That's correct.
10:21:13 Q. Are the narcotic counts only
10:21:16 to be done by registered staff?
10:21:18 A. That's correct.
10:21:19 Q. And is it only the registered
10:21:24 staff coming on and the registered staff coming
10:21:27 off that are supposed to be doing it?

10:21:29 A. Yes, and then the narcotic
10:21:32 keys are to be handed over right after the
10:21:35 narcotic count.
10:21:35 Q. And what do you mean by
10:21:38 "narcotic keys"?
10:21:40 A. Sorry, "medication keys"
10:21:42 would be a better term. Each -- we had three
10:21:49 -- we had four nurses in Section B, that, you
10:21:53 know, changed over years, but when I left we
10:21:59 had four nurses, the Charge Nurse and three
10:22:01 RPNs, and each nurse would have a set of keys.
10:22:11 So when they left, they would
10:22:13 hand their key to their on-coming nurse and the
10:22:18 night nurse would keep all sets of keys.
10:22:20 Q. So when you are saying that
10:22:32 when you left, that would be 2017?
10:22:35 A. Yes.
10:22:38 Q. Okay. And when you say
10:22:44 Charge Nurse plus three RPNs, are you talking
10:22:46 about on the day shift?
10:22:48 A. On the day shift, yes. We
10:22:49 had the highest complement of staff on the day
10:22:52 shift.
10:22:52 Q. In Section B?
10:22:53 A. In Section B.
10:22:53 Q. Okay, we'll get to the
10:22:58 staffing in a moment, but the narcotic drawer
10:23:02 within the medication bin, was that locked or
10:23:05 unlocked?
10:23:06 A. It was supposed to be locked
10:23:07 at all times, the bin itself, not the drawer,
10:23:10 just the bin itself.

10:23:11 Q. So if I open -- I can open
10:23:14 the drawer, once the medication cart is
10:23:16 unlocked; is that correct?
10:23:18 A. That's correct.
10:23:18 Q. And then when I open the
10:23:20 drawer, then what do I see?
10:23:22 A. You would see some bottles of
10:23:25 laxative to the left, and then a bin about
10:23:31 eight inches wide by ten, twelve inches deep.
10:23:37 Q. And is that affixed to the
10:23:39 cart or can I just go and take it out and be on
10:23:42 my way?
10:23:43 A. I don't know. I believe it
10:23:48 was fixed, but I never tried to pull it out.
10:23:51 Q. Okay. That is probably a
10:23:54 good thing. And that bin, I think you said,
10:23:58 was locked?
10:23:59 A. Yes.
10:23:59 Q. And is that lock a separate
10:24:03 key from the unlocking of the medication cart?
10:24:05 A. Yes, it is a little key.
10:24:08 Q. And so is it fair to say then
10:24:13 in respect of narcotics, if I'm a nurse and I
10:24:17 am coming on shift, I get the keys; if I want
10:24:22 to get a narcotic and the medication cart is in
10:24:25 the medication room, I have got a key to the
10:24:28 medication room?
10:24:29 A. Right.
10:24:29 Q. A separate key to the
10:24:31 medication cart?
10:24:32 A. Correct.
10:24:32 Q. And a separate key to the

10:24:33 narcotic bin once I open that drawer?
10:24:36 A. That's correct.
10:24:37 Q. And those keys, I think you
10:24:40 indicated, are turned over from the off-going
10:24:44 nurse to the on-coming nurse?
10:24:46 A. Right after narcotic count.
10:24:49 Q. Now, another thing that was
10:24:54 indicated in prior testimony is at night the
10:24:57 Charge Nurse is in charge of the building; is
10:24:59 that correct?
10:24:59 A. That is correct.
10:25:00 Q. So would the Charge Nurse
10:25:02 have additional keys on her or him for the
10:25:08 building at all?
10:25:09 A. For the building?
10:25:10 Q. Yes.
10:25:11 A. Not that I am aware, no.
10:25:15 Q. Okay. So the keys that they
10:25:18 were in control of are related to the
10:25:19 medication?
10:25:20 A. That's correct. If they had
10:25:22 to lock a door, it was with an Allen key that
10:25:26 was kept around the door somewhere in a hidden
10:25:29 spot.
10:25:29 Q. Okay, and we won't broadcast
10:25:31 to the world where those are kept.
10:25:35 Now, I just want to try to again
10:25:37 do a little bit of education, do a couple of
10:25:40 things at once. So let's just talk about
10:25:42 narcotics. Have there been narcotics that have
10:25:47 gone missing in the home while you were the
10:25:50 Director of Nursing?

10:25:51 A. Would you repeat that
10:25:54 question, please?
10:25:54 Q. Yes. Did you have any
10:25:56 narcotics in the home go missing during the
10:25:59 period that you were Director of Nursing?
10:26:01 A. Yes, I did.
10:26:02 Q. All right. And what is the
10:26:04 process if a narcotic is found missing?
10:26:06 A. Well, the nurse would try and
10:26:10 find it, or the nurses, because it usually was
10:26:16 determined at narcotic count that something was
10:26:19 missing, so they would, you know, check their
10:26:22 bins and see if the pill had, you know, fallen
10:26:26 out inadvertently.
10:26:32 And then if it couldn't be
10:26:34 found, they were to let a supervisor know.
10:26:37 Q. And what would the supervisor
10:26:42 do?
10:26:43 A. We would -- if it was a major
10:26:52 amount, we would call the police.
10:26:57 Q. So were they not reported
10:27:02 with respect to any missing narcotics or only
10:27:05 when there was a certain amount?
10:27:06 A. Well, if the narcotic
10:27:10 couldn't be found, I believe we reported it.
10:27:14 Q. All right. And when you said
10:27:17 the staff should let a supervisor know, what is
10:27:21 the process? Who would be told? What
10:27:24 positions would supervisors be?
10:27:26 A. We had people on call. If I
10:27:29 weren't in the building, then there were people
10:27:33 on call and they would call them after-hours.

10:27:36 Q. All right. So I want to take
10:27:38 you to an example of that, so we can see what
10:27:41 the process is. If I can take you to document
10:27:47 00643, tab MM in your affidavit there.
10:28:01 And we heard a little bit about
10:28:06 these documents yesterday. Are you there,
10:28:14 Helen?
10:28:14 A. Not right yet.
10:28:17 Q. Okay.
10:28:19 A. MM, did you say?
10:28:21 Q. Yes. Towards the back.
10:28:24 Almost at the back.
10:28:28 A. Yeah, I have got it here.
10:28:29 Q. Now, this is a Critical
10:28:38 Incident Report that appears to have been
10:28:40 submitted on March 15, 2013; am I right on
10:28:45 reading that date?
10:28:46 A. That's correct.
10:28:47 Q. And the critical incident
10:28:51 date and time, March 14, 2013, 23:30?
10:28:58 A. Correct.
10:28:59 Q. That would be the evening
10:29:00 shift; is that correct?
10:29:00 A. Yes.
10:29:01 Q. And then it has medication --
10:29:09 or "location, please specify," "medication room
10:29:16 in Section B"?
10:29:18 A. Yes.
10:29:18 Q. And in respect of the
10:29:20 description of the incident it states:
10:29:22 "During narcotic count by two
10:29:24 RNs at shift change between

evening shift and night shift it was noted that 1 capsule of Kadian SR 10 mg. was missing. The narcotic count between day and evening shift earlier in the day was correct. It is possible that resident may have received a double dose as B. Wettlaufer, RN reported that bin was searched and capsule could not be found."

So that, I think you were just saying the first thing they do is see if they can find that capsule?

A. That's correct.

Q. And then they couldn't find it, and it was reported and a Critical Incident Report is made out?

A. That's correct.

Q. All right. And if we go to page number 2 of that document under "Actions taken" it states:

"B. Wettlaufer, RN notified the manager on call at 00:36, which was myself, H. Crombez. RN stated that there was a delay in reporting as they searched the lower drawer/bin for the capsule but could not find it. H. Crombez asked that Police Department be notified and investigate which was done.

10:30:48 1 Cst. Randy Rudy came to the
10:30:53 2 nursing home and interviewed
10:30:56 3 both B. Wettlaufer and L.
10:30:58 4 Durbidge [...]"
10:31:01 5 And then you give an incident
10:31:02 6 number, and then it talks about how the
10:31:04 7 resident was that particular night. Now, the
10:31:14 8 police were called and interviewed both
10:31:20 9 Elizabeth Wettlaufer and another employee. L.
10:31:23 10 Durbidge, is that an RN or an RPN?
10:31:25 11 A. She was an RN.
10:31:26 12 Q. To the best of your
10:31:27 13 knowledge, were any charges laid?
10:31:29 14 A. I don't know of any.
10:31:30 15 Q. Did you do an internal
10:31:32 16 investigation as well?
10:31:33 17 A. I can't recall.
10:31:37 18 Q. Well, let me help you out
10:31:39 19 just a bit. If you go to document 16814 in
10:31:48 20 that particular -- now I'm at, sorry -- give me
10:32:02 21 two seconds.
10:32:02 22 Yes, in that same tab MM, it is
10:32:07 23 the next document, 16814. Whose handwriting is
10:32:11 24 this?
10:32:11 25 A. This is Brenda's handwriting.
10:32:14 26 Q. Okay, and do you know if you
10:32:17 27 were in attendance at this meeting?
10:32:18 28 A. I believe I was talking.
10:32:22 29 Q. All right. What was your
10:32:23 30 normal process when there was a meeting with an
10:32:26 31 employee with whom you were discussing some
10:32:30 32 issues?

10:32:30 A. If it was a nursing issue, then Brenda liked me to talk, and then she would take the notes.
10:32:38 Q. Okay. And can you just read -- I just want to make sure that -- if you can just read the part that says "At supper [...]" and go down to "giving earlier"?
10:33:09 A. "At supper she will complain of a headache, will give at 6:15 will give along with Tylenol. I think I did that and didn't sign off. Bethe said I did 3 things wrong.
1, not signing MAR.
2, [not signing narcotic sheet].
3, giving earlier."
10:33:36 Q. Does she say actually "sheet" on your copy, or just -- you said "not signing narcotic sheet." Does it say "sheet"?
10:33:47 A. No, it doesn't, but that is what the "Nar" means.
10:33:52 Q. That is what you assume. So it appears from this document that Elizabeth Wettlaufer was forthcoming in what she had done wrong with that particular situation?
10:34:00 A. Yes.
10:34:00 Q. Now, in general, how did you find Elizabeth Wettlaufer's demeanour when you were investigating these types of incidents or disciplining her?
10:34:15 A. She was usually open and frank, would admit her mistake.

10:34:38 Q. And did she ever blame anyone
10:34:41 else for the mistakes, in your opinion?
10:34:43 A. No, she took ownership of her
10:34:48 mistake.
10:34:48 Q. And if I can just finally
10:34:53 take you to document 16813, and can you tell us
10:35:07 what this document is?
10:35:08 A. This is a Disciplinary Action
10:35:16 Form.
10:35:16 Q. And is this -- what was this
10:35:20 discipline for?
10:35:21 A. This was for the narcotic
10:35:24 that she couldn't account for on her shift.
10:35:28 Q. All right, and was that one
10:35:31 narcotic, one pill?
10:35:32 A. Yes, I believe so.
10:35:35 Q. And the discipline that you
10:35:37 gave her?
10:35:42 A. "A one-day suspension with
10:35:44 notice that continued poor work
10:35:47 performance related to
10:35:48 medication issues or resident
10:35:51 care issues will result in
10:35:52 disciplinary action up to and
10:35:54 including termination."
10:35:59 Q. Now, in the bottom left-hand
10:36:02 corner you signed as the signature of the
10:36:03 immediate supervisor; is that correct?
10:36:05 A. That's correct.
10:36:05 Q. And then Ms. Van Quaethem as
10:36:07 the manager?
10:36:08 A. That's correct.

10:36:08 Q. Now, over on the right-hand
10:36:12 side, there is a signature line for originally
10:36:17 a union rep and this has been crossed out and
10:36:21 it says "witness." So what was -- your nurses
10:36:28 were unionized; correct?
10:36:29 A. That's correct.
10:36:30 Q. And would they have a
10:36:32 representative in the home?
10:36:34 A. We did have at times. Karen
10:36:40 Routledge was a representative for quite
10:36:43 awhile, and then Mina Giraldi was, but then
10:36:48 there was no one else willing to take that role
10:36:51 on. So we just called a fellow RN to act as a
10:36:59 witness for the person being disciplined.
10:37:03 Q. And they would identify that
10:37:09 they were aware of the discipline that was
10:37:11 provided?
10:37:12 A. That's correct.
10:37:12 Q. Now, in terms of what Ms.
10:37:16 Wettlaufer would be given, would she be given a
10:37:17 copy of the discipline form?
10:37:19 A. That's correct.
10:37:19 Q. And if an ONA representative
10:37:22 was available, would they have access to a
10:37:24 copy?
10:37:24 A. If an ONA representative was
10:37:28 available, yes, certainly.
10:37:32 Q. And if it was a witness,
10:37:33 would the witness be given a copy?
10:37:35 A. I believe we did, yes.
10:37:36 Q. Okay. Now, in the bottom
10:37:55 left-hand corner, whose handwriting is that on

this document?
A. That is Brenda's.
Q. And are you able to read that writing?
A. Yes. Brenda wrote that: "[I] reviewed the medication administration protocol [with Bethe]."
That I wanted her to sign or initial at each bubble for narcotics or controlled substances when she punched it out, and sign on the individual narcotic sheet at the time that the bubble was emptied.
Q. So are these steps taken in addition to the one-day suspension Ms. Wettlaufer got?
A. This was re-education for Bethe Wettlaufer.
Q. Would you generally do that when you had a nurse in to talk about medication errors?
A. Well, sometimes we would ask if they wanted re-education and sometimes I would just go ahead and do it.
Q. Thank you. Now, I just want to, while we are at it, look at one more narcotic incident that Mr. Sandler, I think, raised yesterday. If I can bring you to document 00643 -- sorry, no -- sorry, just give me one moment. It is the same one, but back to

10:39:39 1 00643. And if you can go to the third page,
10:39:50 2 under "Analysis and follow-up," it states:
10:39:53 3 "Memo to all registered staff
10:39:54 4 that starting immediately they
10:39:56 5 are to initial the bubble of
10:39:57 6 each medication that they pop
10:39:58 7 out of medication card. This
10:40:01 8 step is in addition to their
10:40:03 9 regular charting, recording and
10:40:04 10 counting of narcotics and
10:40:09 11 controlled substances. Incident
10:40:11 12 is being investigated and staff
10:40:13 13 are being interviewed.
10:40:14 14 What long-term actions are
10:40:16 15 planned to correct this
10:40:19 16 situation and prevent
10:40:20 17 recurrence?
10:40:21 18 Ongoing education regarding
10:40:23 19 medication administration,
10:40:24 20 following protocols for
10:40:25 21 narcotics and prompt reporting
10:40:26 22 of discrepancies."
10:40:28 23 So is that additional steps that
10:40:30 24 you took?
10:40:31 25 A. Yes.
10:40:32 26 Q. And just to clear up, when
10:40:34 27 you say they are to initial the bubble of each
10:40:36 28 medication that they pop out, what do you mean
10:40:40 29 by that?
10:40:41 30 A. Well, on that narcotic card
10:40:48 31 that we saw, some nurses, you know, would
10:40:50 32 automatically just initial it and circle it,

you know, that that was the one they took, but others, you know, thought it was duplicate documentation, if you will, taking more time, and I, after this incident, you know, I told them that this needed to happen.

Q. So this is actually having to sign on the card that has the actual pills in it; is that --

A. That's correct.

Q. So they had to do that, but they also had to fill out that other sheet we talked about?

A. Yes, as well as the Medication Administration Record.

Q. So that they had given it?

A. Uhm-hmm.

Q. Okay. So let me just --

A. And if it was a PRN, they had to put it in the Progress Notes, so there was a lot of work involved around a PRN narcotic.

Q. So PRN narcotic, they would have to sign the actual card that contains the pill; correct?

A. Uhm-hmm.

Q. You have to say yes or no.

A. Yes.

Q. They would have to sign that narcotic sheet that goes from 31 to 1; is that correct?

A. Yes.

Q. But that is not the Medication Administration Record; is that what

you just said?
A. That's correct.
Q. So they would have to sign off on the Medication Administration Record that it had been given?
A. That's correct.
Q. And then you said if it was a PRN, that they would have to note that in the Progress Notes for the resident?
A. That's correct.
Q. So four sets of documenting what has been done with that one narcotic pill?
A. That's right. And if they were a really good nurse, they would go back and find out what the effect was and chart that as well.
Q. A really good nurse or a really good nurse who had time?
A. Sorry?
Q. So did you expect that of all your nurses?
A. Yes, I expected them to know what the pain level was and go back and make sure that it had been effective.
Q. Would you review Progress Notes made by your nurses?
A. I tried to, yes.
Q. And would you point out things such as that to them?
A. Yes.
Q. Now, we'll go back to medication management. And sorry,

10:43:11 Commissioner, for flipping back and forth, but
10:43:13 I just wanted to give some actual examples of
10:43:16 these types of things that we are talking
10:43:18 about?
10:43:18 THE COMMISSIONER: That is very
10:43:19 helpful, thank you.
10:43:20 BY MS. HEWITT:
10:43:20 Q. If we can go back to
10:43:22 medication management and paragraph 50 of your
10:43:24 affidavit, I want to talk a bit about
10:43:33 destruction of drugs that are in the home.
10:43:38 So we'll talk first about
10:43:45 non-controlled drug substances. Paragraph 50
10:43:48 of your affidavit states:
10:43:58 "In terms of the destruction of
10:43:59 non-controlled drug substances,
10:44:03 each medication room has their
10:44:05 own non-controlled drug
10:44:07 destruction box. In terms of
10:44:10 discarding the empty medication
10:44:12 strip packages [...]"
10:44:15 And actually I'm going to skip
10:44:17 that, Commissioner, because that just talks
10:44:19 about what you do with the -- once you give the
10:44:21 pills what you do with the plastic strips;
10:44:24 correct?
10:44:24 A. Yes.
10:44:24 Q. And what your affidavit
10:44:26 there says is that you do things to make sure
10:44:29 that the resident's name has been taken off and
10:44:32 then --
10:44:33 A. We tried to protect the

10:44:35 1 resident's privacy.
10:44:37 2 Q. But that is not actually
10:44:42 3 medication, so we'll go down to paragraph 52:
10:44:45 4 "Every month, the pharmacist
10:44:46 5 consultant comes in and would
10:44:48 6 ask the charge nurse to open the
10:44:49 7 medication room. The nurse
10:44:50 8 would pull out the
10:44:52 9 non-controlled destruction box,
10:44:53 10 inform the Pharmacy Consultant
10:44:54 11 who had died or transferred,
10:44:57 12 changes in direction for a
10:44:58 13 resident or whatever question
10:45:00 14 might come to mind."
10:45:02 15 And it is not fairly clear, but
10:45:05 16 when -- under what circumstances would some
10:45:08 17 non-controlled medications have to be put in
10:45:11 18 that destruction box?
10:45:12 19 A. If a resident died, their
10:45:20 20 non-controlled medications would be put in
10:45:22 21 there. Most long-term care facilities didn't
10:45:33 22 want to have our medication sent with the
10:45:37 23 resident, just the MAR, so we would put, if
10:45:39 24 they were transferred, put anything that was
10:45:41 25 left in the box.
10:45:44 26 There might be a change in
10:45:46 27 direction for a resident, so say, for instance,
10:45:55 28 Lasix 40 was changed to Lasix 20 -- that might
10:46:03 29 not be a good example, but there would be two
10:46:05 30 tablets of Lasix 20 there perhaps, so you would
10:46:11 31 take out one 20, tape up the strip pack and put
10:46:14 32 a change of direction label in it and then

10:46:16 1 throw the extra Lasix pill in the box, that
10:46:20 2 kind of thing.
10:46:20 3 Q. All right. And so with
10:46:23 4 respect -- I'll just have you clarify one
10:46:26 5 thing. You said if somebody was transferred,
10:46:28 6 most places didn't want you to send the
10:46:29 7 medication with the resident.
10:46:31 8 A. That's right.
10:46:32 9 Q. So I'll just fill in that a
10:46:33 10 bit.
10:46:34 11 If you transfer a resident to
10:46:37 12 the hospital and the resident is admitted for a
10:46:40 13 week, do the medications that you have on hand
10:46:44 14 in the home for that week, do those go with the
10:46:48 15 resident to the hospital?
10:46:49 16 A. No, they do not.
10:46:52 17 Q. And are those the types of
10:46:54 18 drugs for that particular -- ordered for that
10:46:57 19 week that would go in the non-destruction,
10:46:59 20 non-controlled destruction box?
10:47:01 21 A. Yes. Now, it did happen once
10:47:05 22 in awhile that the hospital wouldn't have the
10:47:06 23 right medication, so they would ask us to bring
10:47:09 24 it over.
10:47:09 25 Q. But other than --
10:47:11 26 A. And that was rarely.
10:47:12 27 Q. But other than that, they
10:47:13 28 wanted to prescribe them itself?
10:47:16 29 A. That's right.
10:47:16 30 Q. So once every month a
10:47:20 31 pharmacist consultant comes in and takes this
10:47:23 32 box with how many pills have ended up there

10:47:26 during the month, and you go on to say:
10:47:28 "The medications would be put in
10:47:29 a double garbage bag and
10:47:31 destroyed. They are denatured
10:47:34 at the time of destruction by
10:47:36 running water into the bag and
10:47:37 covering with liquid antacid,
10:47:40 liquid laxative or cough syrup.
10:47:42 The denatured medications are
10:47:44 then packaged up and taken to a
10:47:45 storage area right away. The
10:47:48 storage area," at Caressant
10:47:51 Care, I should say, "is in the
10:47:53 basement in the medication room.
10:47:56 All nurses that are on duty have
10:47:57 access to that room."
10:47:58 So just clarify a bit this
10:48:01 process of denaturing, what does it do to the
10:48:05 non-controlled drugs?
10:48:06 A. Well, the pills come apart
10:48:12 and over time that bag becomes like a solid
10:48:18 mass.
10:48:18 Q. You mean when they come
10:48:22 apart, they get crushed or broken --
10:48:24 A. They get dissolved in the
10:48:25 liquid.
10:48:25 Q. And that is done with the
10:48:27 consultant pharmacist?
10:48:28 A. That's right. And I would
10:48:30 take that bag -- when she was done, she would
10:48:32 bring it to me and I would take that bag
10:48:35 downstairs right away.

10:48:36 Q. And then it goes on in
10:48:44 paragraph 53 to say:
10:48:44 "Once the box in the basement
10:48:46 was three-quarters full [...]"
10:48:49 So this would be done in each
10:48:50 medication room?
10:48:51 A. Yes.
10:48:51 Q. So there is a non-controlled
10:48:54 drug destruction box in each medication room?
10:48:57 A. That's correct.
10:48:57 Q. So the same process?
10:48:59 A. Yes.
10:49:00 Q. All of them taken to the same
10:49:01 area in the basement?
10:49:03 A. That's correct.
10:49:03 Q. Okay and then you go on to
10:49:06 state that:
10:49:07 "Once the box in the basement
10:49:08 was three-quarters full,
10:49:10 maintenance would take the full
10:49:11 box to their storage area in the
10:49:12 lower level. There was limited
10:49:14 access to this storage room."
10:49:16 And then you go on to talk about
10:49:18 how that box and the sharps containers would be
10:49:22 collected by the nursing staff.
10:49:24 Now, what is a sharps container?
10:49:25 A. A sharps container is where
10:49:30 we would put the needles that were used during
10:49:35 medication administration. And some nurses
10:49:41 would also put the insulin vials in there as it
10:49:47 was a little glass container.

10:49:49 Q. And when you say "vials," because we are going to get to insulin momentarily, but at one point in time, as I understood your evidence in the affidavit, at one point in time there may have been vials and needles, but now it is pen and cartridge?
10:50:05 A. That's correct.
10:50:06 Q. But when you just indicated vial, would you also mean cartridge?
10:50:11 A. That's correct.
10:50:11 Q. All right. So some -- and we'll get to insulin, Commissioner, but some cartridges of insulin would end up in the sharps container?
10:50:21 A. Yes, I believe so.
10:50:23 Q. All right. Now, once in the sharps container, am I or is any other person able to open the container and get that cartridge out?
10:50:36 A. Not easily. I mean, you could cut the container open and then put everything else in a new container.
10:50:44 Q. But other than going to the steps of having to cut the sharps container open, is there any other mechanism to open it that is at the home?
10:50:53 A. No. It was -- it had, like, little teeth. You know, if you stuck your hand too far, you would get scratched or grabbed or whatever.
10:51:04 Q. And in your experience at Caressant Care, did any of the sharps

10:51:08 containers ever get, you know, damaged such
10:51:13 that you would suspect somebody was into the
10:51:15 sharps container?
10:51:16 A. No.
10:51:16 Q. Okay. So we have talked
10:51:19 about non-controlled drugs and the pharmacist
10:51:22 coming in, everything goes into a bag, water,
10:51:25 whatever the substance is, you indicated after
10:51:28 a time it becomes a big mess, blob?
10:51:31 A. Mass.
10:51:32 Q. Mass. When the pharmacist is
10:51:35 doing that, is he or she doing it with a nurse?
10:51:38 A. Yes.
10:51:39 Q. And at the same time are they
10:51:42 identifying what is being denatured, Joe
10:51:47 Smith's cycle pack for the last --
10:51:50 A. They would talk about why the
10:51:51 medication was there.
10:51:52 Q. But any counting of Joe Smith
10:51:56 went to the hospital on Wednesday, we are now
10:51:59 throwing away two cycle packs?
10:52:01 A. No, there was no counting.
10:52:03 Q. So for non-controlled drugs,
10:52:05 they simply got denatured, no counting?
10:52:07 A. That's correct.
10:52:08 Q. Okay. Now, I understand
10:52:15 there is a separate system with respect to
10:52:17 controlled drugs?
10:52:18 A. That's correct.
10:52:19 Q. Okay. So if we can go to
10:52:22 paragraph 54 of your affidavit:
10:52:33 "The narcotics to be destroyed

10:52:34 1 are put into a separate box and
10:52:36 2 it's bolted to the floor in
10:52:38 3 Section B med room."
10:52:41 4 So is that the only place in the
10:52:44 5 home that there is this box that is bolted to
10:52:49 6 the floor?
10:52:49 7 A. Yes.
10:52:50 8 Q. All right. I guess if I just
10:52:54 9 kept reading, I could have answered my own
10:52:56 10 question:
10:52:57 11 "There was only one narcotic
10:52:59 12 destruction box for the nursing
10:53:00 13 home. The narcotic and the
10:53:01 14 narcotic count sheet [...]"
10:53:04 15 Is that the sheet we went over
10:53:06 16 this morning that starts with 31 and goes down
10:53:08 17 to 1?
10:53:10 18 A. That's correct.
10:53:10 19 "[...] are put in the
10:53:12 20 narcotic destruction box,
10:53:13 21 wrapped together with an elastic
10:53:16 22 and two nurses sign that they
10:53:17 23 see it go into the box. The
10:53:20 24 medication stays there until the
10:53:22 25 Pharmacy Consultant comes to do
10:53:27 26 drug destruction. She reviews
10:53:29 27 the list with the cards [...]"
10:53:31 28 And by that do you mean the
10:53:32 29 cards that contain the drugs?
10:53:34 30 A. That's correct.
10:53:35 31 Q. "[...] or the patches [...]"
10:53:38 32 Would that be -- what type of

10:53:40 1 patch would there be?
10:53:41 2 A. A fentanyl patch.
10:53:43 3 Q. "[...] or whatever it may be,
10:53:45 4 and if there's a discrepancy she
10:53:47 5 talks to me about it. Only the
10:53:48 6 Pharmacy Consultant and I had
10:53:49 7 keys to the narcotic destruction
10:53:51 8 box. Usually it was the
10:53:52 9 Pharmacy Consultant and the
10:53:53 10 Charge Nurse that did the
10:53:54 11 destruction."
10:53:55 12 So let's unpack that a moment.
10:54:00 13 So these are narcotics to be
10:54:02 14 destroyed. So if we take Mr. Smith goes to the
10:54:06 15 hospital and is admitted, would his narcotics
10:54:11 16 for the week also have to be destroyed?
10:54:13 17 A. No, because that -- it wasn't
10:54:20 18 a weekly card, so it was, you know, an ongoing
10:54:25 19 card. So you would just start where it left
10:54:28 20 off when he came back from hospital.
10:54:30 21 Q. So under what circumstances
10:54:32 22 would a narcotic card with narcotics left in it
10:54:36 23 be put in this narcotic destruction box?
10:54:39 24 A. Well, if the resident didn't
10:54:43 25 need it anymore or the resident died or the
10:54:48 26 resident was transferred out of the facility.
10:54:51 27 Q. So when you indicate didn't
10:54:56 28 need it anymore, could that be a change of
10:54:58 29 doctor's orders then?
10:54:59 30 A. Yes. So they might have
10:55:01 31 Tylenol number 2. It is not effective anymore,
10:55:05 32 so then the doctor might order Tylenol number 3

10:55:08 or Dilaudid or something stronger and we would
10:55:12 get rid of the other.
10:55:14 Q. So your evidence was both the
10:55:16 narcotic card and the narcotic sheet go into
10:55:19 that box?
10:55:20 A. Yes, and they would be
10:55:22 wrapped together to make it easy for the
10:55:25 destruction and the Pharmacy Consultant to see
10:55:29 what was there.
10:55:30 Q. And so what does that sheet
10:55:33 tell the Pharmacy Consultant?
10:55:34 A. The sheet would tell the
10:55:38 Pharmacy Consultant how many medications were
10:55:41 supposed to be in the card and she would look
10:55:45 at the card and see that everything was okay.
10:55:50 Then she would punch the pills
10:55:52 out into another, you know, double-bagged
10:55:55 plastic bag, and -- or it could be the same bag
10:56:02 if she was doing everything that day, and
10:56:06 denature them.
10:56:06 Q. The same type of process that
10:56:09 we talked about earlier?
10:56:10 A. That's correct.
10:56:11 Q. Okay. And if there is a
10:56:12 discrepancy, if he or she, the pharmacist, is
10:56:18 looking at the count sheet and it is down to 15
10:56:22 remaining and on the card there's two, on the
10:56:28 card there's only two pills in the card, what
10:56:30 is the process?
10:56:30 A. Well, she would come to me
10:56:33 and point out the problem and I would call the
10:56:39 police.

10:56:40 Q. The narcotic destruction box, although the nurses can get into the medication room, I think your evidence was only you and the Pharmacy Consultant could actually get into that box; is that correct?
10:57:00 A. That's right. I had a key in case someone threw something in there inadvertently and needed it back out.
10:57:07 Q. So --
10:57:11 A. I never used it.
10:57:12 Q. So is it your evidence then that it would be the Pharmacy Consultant that would use it?
10:57:22 A. Yes, I never had need to use my key for that purpose.
10:57:25 Q. And if I could turn, Commissioner, this is not an exhibit in your affidavit, but it is in the Overview Report, Exhibit No. 6. If I can turn to document 00623, because I think this will assist in helping our understanding of this process.
10:58:01 A. And where do I find that, sorry?
10:58:03 Q. You are going to have to read it on the screen in front of you, Mrs. Crombez.
10:58:11 And this is a Critical Incident Report dated April 16th, 2013; is that correct?
10:58:20 A. That's correct.
10:58:22 Q. And the date and time of the incident is April 16th, 2013, 17:10, and the date and time it is submitted is the same date 17:19, nine minutes later; do you see that?

10:58:37 A. Yes.
10:58:37 Q. And it identifies, if we
10:58:40 scroll down, the location is "med room Section
10:58:44 B"?
10:58:45 A. Yes.
10:58:45 Q. And then in the description
10:58:47 of the incident it states:
10:58:49 "Today our Pharmacy Consultant,
10:58:52 Candace Pink, reported to us
10:58:54 that when she was in to destroy
10:58:55 meds she found an individual
10:58:58 narcotic card of 31 tablets of
10:59:00 hydromorphone 1 mg. missing. It
10:59:04 appears that the tablets were
10:59:06 put in the medication
10:59:07 destruction box by Lois
10:59:11 Durbidge, RN and Jennifer Hague
10:59:15 RN on March 21, 2013."
10:59:18 So let me just ask one question.
10:59:19 When as a nurse I'm going to put something into
10:59:21 the drug narcotic box, destruction box, do I
10:59:26 have to have a witness?
10:59:27 A. Yes. We needed two people to
10:59:32 see it, two nurses to see it go into that box.
10:59:35 Q. Is that the same process with
10:59:36 the non-controlled drug box?
10:59:39 A. No.
10:59:40 Q. So if I am getting rid of
10:59:43 Mr. Smith's extra cycle packs because his
10:59:50 medication has been changed, I can do that
10:59:51 myself?
10:59:52 A. That's correct.

10:59:52 Q. But your evidence is that if it is a narcotic, someone has got to watch me do that?
10:59:57 A. That's correct.
10:59:58 Q. And would that be why it refers to it appears that the tablets were put in the medication destruction box by Lois Durbidge and Jennifer Hague on March 21st?
11:00:11 A. Yes.
11:00:11 Q. So would they have to sign off that is the actually date they put it in the drug destruction box?
11:00:17 A. That's correct.
11:00:17 Q. It goes on to state:
11:00:20 "Police have been called and an
11:00:22 investigation will take place
11:00:22 starting tomorrow morning
11:00:23 possibly at 6:30 a.m. as the
11:00:26 police advised us to call them
11:00:27 in the morning to start the
11:00:28 investigation when both of these
11:00:30 staff members are working."
11:00:33 Now, I note here that the date that the tablets were put in the box is March 21st, and am I right that the date it was discovered is almost a month later, April 16th, 2013?
11:00:48 A. That's correct.
11:00:48 Q. And so between those two dates, would there be more than one individual that would have access to the medication room in Section B?
11:00:59

11:01:00 A. Yes, certainly.
11:01:01 Q. It would be a different nurse
11:01:03 every shift; am I right on that?
11:01:05 A. Yes.
11:01:05 Q. And then if we go to "Actions
11:01:12 taken," it states:
11:01:20 "Investigation taking place.
11:01:22 Narcotic Disposal Box inspected
11:01:25 by B. Van Quaethem and H.
11:01:27 Crombez April 16/13 and found to
11:01:31 have a gap where possibly a
11:01:33 medication card could be removed
11:01:35 by sticking your hand in or
11:01:37 using tongs."
11:01:41 So you and Ms. Van Quaethem
11:01:42 discovered that, did you?
11:01:44 A. Yes.
11:01:46 Q. "We showed C. Pink this and
11:01:48 she has put in a request for
11:01:50 equipment service to this box or
11:01:51 a replacement for this box.
11:01:53 Request is marked as 'urgent'."
11:01:58 Are those boxes provided by the
11:02:00 pharmacy then?
11:02:00 A. Yes, they are.
11:02:01 Q. "Constable McLeod in this
11:02:06 morning, April 17, 2013. He
11:02:09 spoke with B. Van Quaethem and
11:02:11 H. Crombez regarding the process
11:02:14 of medication disposal and
11:02:16 examined the Narcotic Disposal
11:02:18 Box. He interviewed both J.

Hague and L. Durbidge privately in the office. Constable McLeod took a list of names of registered staff, RN and RPN, that work here and also a list of staff who worked night shift alone on this side of the building. He said he would run some names through their computer, looking at spouses, addresses, etc. He is involved in drug investigations in Woodstock and knows this medication is available on the street. He said he may work backwards and talk to people who deal in drugs and see what he can shake out."

To the best of your knowledge, was there anyone charged with this particular missing narcotic in your home?

A. I can't recall. I don't believe there was.

Q. Do you remember ever disciplining anybody for having taken 31 --

A. No, I don't recall.

Q. All right. And would you have cooperated with the police and provided them with a list of all of the individuals who would have had access to that medication room between those two dates?

A. Certainly I would have given

him names and phone numbers.

Q. Okay. Now, if we can go to the next page "Analysis and follow-up":

"Investigation ongoing.

Narcotic Disposal Box was replaced with a newer, more secure model April 17/13. It was also screwed to the cement floor from inside the box to make stealing from it more difficult.

Investigating at present.

Approval has been received from Head Office to install a hidden security camera as this was a suggestion made by the police officer. B. Van Quaethem has contacted A. LeBell, IT, regarding this."

Do you know whether or not that was ever done, was there ever something placed in that?

A. No, there was never a camera installed, but we kind of talked like there was, so that it, you know, would possibly hinder someone from taking more medication.

Q. Do you know the reason why you didn't actually install a camera?

A. I don't know.

Q. Okay. But you indicated to the staff there was a camera; is that what you are saying?

11:04:46 A. Well, you know, I would say
11:04:49 things like, oh, you know, candid camera, you
11:04:53 never know.
11:04:54 Q. Okay. So now I want to talk
11:05:03 about insulin. Insulin, as I understand your
11:05:08 affidavit, is not a controlled drug?
11:05:10 A. That's correct.
11:05:17 MS. HEWITT: Commissioner, would
11:05:19 you like us to -- I'm getting
11:05:23 into a whole new area, would you
11:05:25 like to take the morning break?
11:05:26 I'm in your hands.
11:05:27 THE COMMISSIONER: How long are
11:05:29 you going to be in this area?
11:05:30 MS. HEWITT: Quite awhile,
11:05:31 because it is the whole handling
11:05:32 of insulin.
11:05:33 THE COMMISSIONER: No, I think
11:05:34 it would be wise to take the
11:05:35 morning break now.
11:05:36 Just before we do that, I had an
11:05:40 email suggesting that we might
11:05:41 need to make a change to the
11:05:43 lunch recess time.
11:05:45 MS. HEWITT: There is a request
11:05:46 to make that change. I haven't
11:05:48 canvassed counsel, but I am
11:05:51 going to suggest it is probably
11:05:54 we would rather make that change
11:05:55 for Monday. It is a Friday, and
11:05:57 so rather than sitting a little
11:05:58 later and having a longer lunch,

11:06:01 I suspect counsel would rather
11:06:04 go back to Toronto, so the
11:06:06 suggestion was a longer lunch
11:06:07 hour because we know that
11:06:09 everybody is cooperating with
11:06:11 each other, but sit for 15
11:06:14 minutes more. So it is my
11:06:17 suggestion that we potentially
11:06:18 start that on Monday?
11:06:23 THE COMMISSIONER: So today is
11:06:24 going to be a normal lunch hour
11:06:25 and a normal closing time, but
11:06:27 going forward, starting on
11:06:28 Monday, the lunch hour will be
11:06:30 an hour and 15 minutes, and
11:06:34 correspondingly 15 minutes later
11:06:38 at closing each day?
11:06:39 MS. HEWITT: Yes, and that is to
11:06:40 give everybody the opportunity
11:06:41 to -- there is a lot of
11:06:42 conferring to try to make this
11:06:44 process more expeditious during
11:06:46 the lunch hour, so it shortens
11:06:48 any ability for anybody to
11:06:49 actually go out of the building
11:06:50 and get nourishment.
11:06:52 THE COMMISSIONER: Yes. No,
11:06:54 everybody needs to have a health
11:06:55 break and food, but I understand
11:06:58 that there's lots that happens
11:07:00 behind the scenes at lunchtime
11:07:01 and that makes sense.

11:07:03 MR. SANDLER: Actually, the
11:07:04 Inquiry would move much more
11:07:06 quickly, Commissioner, if we
11:07:08 were precluded from having food
11:07:09 and drink at any time.
11:07:11 THE COMMISSIONER: It might be
11:07:11 hard for anybody with diabetes,
11:07:13 but we won't go there. All
11:07:15 right, thank you, so we'll take
11:07:16 our 15-minute recess now.
11:07:19 -- RECESSED AT 11:07 A.M.
11:16:54 -- RESUMED AT 11:25 A.M.
11:26:07 BY MS. HEWITT:
11:26:07 Q. Thank you, Commissioner.
11:26:08 Now, Helen, I wanted to talk
11:26:11 about insulin, and we do know that we are going
11:26:14 to have Registered Nurses here throughout the
11:26:16 Inquiry at times, so I understand in your
11:26:20 affidavit you have identified you haven't given
11:26:23 insulin in quite some time in your career; is
11:26:25 that correct?
11:26:25 A. That's correct.
11:26:26 Q. But in general, you are aware
11:26:28 of the way that insulin was handled within
11:26:31 Caressant Care?
11:26:31 A. I believe I do.
11:26:35 Q. So I'm going to do the same
11:26:37 thing that I just did with respect to the
11:26:39 medication management, is go through your
11:26:42 affidavit and then we'll stop and I'll ask some
11:26:46 clarification questions.
11:26:47 So if I can turn you then to the

affidavit, and in particular, paragraph 59(a), page 12. When we describe these things, Commissioner, just to let you know that you will be able to get your hands on what we are talking about. We are -- we will be bringing live props for you to allow you to actually see the system and work. But for now, it is just going to be described by Helen.

So at paragraph 59a. it identifies:

"The insulin cartridges come in a box."

Now, you indicated earlier that at the time that Elizabeth Wettlaufer was at Caressant Care, the residents were on a system where they used a pen and cartridge system?

A. Yes, that's correct.

Q. And so the cartridges themselves then, you have indicated, come in a box.

"The box is labelled - resident's name, drug, how often to be given, doctor's name, date filled, Rx number."

And an expiry date; is that correct?

A. That's correct.

Q. So is there a shelf life then for insulin?

A. Once insulin was removed from the fridge, it had a life of 30 days, and the nurses would mark that on their calendar that

11:28:37 1 hung in the med room to replace so-and-so's
11:28:41 2 insulin.
11:28:42 3 And then the box had an expiry
11:28:47 4 date for the medication that was kept in the
11:28:51 5 fridge.
11:28:51 6 Q. And the information that is
11:28:52 7 found on the cartridge box, I won't take you
11:28:57 8 there, but earlier we were talking about the
11:28:59 9 narcotic card and you gave us all the
11:29:01 10 information at the top. Is that the same
11:29:04 11 information that would be on the insulin box?
11:29:05 12 A. That's correct.
11:29:06 13 Q. You indicate in paragraph b.
11:29:14 14 that:
11:29:14 15 "There was a peel away label on
11:29:16 16 the cartridge box. You would
11:29:17 17 take that label and place it in
11:29:19 18 the drug record book, sign off
11:29:22 19 on it and then fax it to the
11:29:24 20 pharmacy."
11:29:27 21 And is that for the purposes of
11:29:30 22 re-ordering insulin?
11:29:31 23 A. That's correct.
11:29:33 24 Q. "With the computerized
11:29:36 25 medication administration, I
11:29:37 26 believe that insulin was
11:29:38 27 re-ordered through the
11:29:40 28 Medication Administration Record
11:29:40 29 on the computer."
11:29:42 30 A. Yes.
11:29:42 31 Q. "Medications were usually
11:29:46 32 received just before supper,

11:29:48 4:30-5:00 p.m. They were
11:29:52 delivered by a delivery service
11:29:53 contracted by the pharmacy."
11:29:55 A. Yes.
11:29:56 Q. And then you go on to talk
11:29:58 about the medications being in a big bag and
11:30:01 the narcotics. Would the insulin cartridges
11:30:03 package or insulin boxes of cartridges be
11:30:11 packaged separately from the cycle strips and
11:30:14 the narcotics or all in the same bag, or how
11:30:17 would that happen?
11:30:18 A. It would be separate from the
11:30:20 cycle-fill. It would be in that paper bag, I
11:30:22 believe.
11:30:22 Q. But packaged on its own?
11:30:24 A. Packaged on its own.
11:30:27 Q. In paragraph e. you indicate:
11:30:32 "The delivery person would go to
11:30:33 the nurse in charge, say that he
11:30:35 has the medications [...]"
11:30:37 And this is all the medications,
11:30:40 correct?
11:30:41 A. That's correct.
11:30:43 "[...] she would walk to the
11:30:44 medication room, sign that she
11:30:45 had received the medications and
11:30:46 the narcotics. There was a form
11:30:47 to sign in the medication room.
11:30:49 The delivery person would sign
11:30:50 that he/she had delivered and
11:30:52 the nurse would initial that it
11:30:54 had been delivered. The nurse

11:30:56 1 would pull out the narcotics and
11:30:57 2 put them into the medication
11:30:59 3 cart right away. Narcotics are
11:31:01 4 counted [...]"
11:31:04 5 And we have gone over that this
11:31:06 6 morning. In paragraph f. you said:
11:31:08 7 "When the insulin was received
11:31:11 8 in the home, the nurse would
11:31:12 9 have to match what was received
11:31:13 10 to what was faxed to the
11:31:15 11 pharmacy."
11:31:15 12 And just briefly, what process
11:31:17 13 would they go through?
11:31:19 14 A. This was, you know, the
11:31:24 15 earlier system when we talk in b. about the
11:31:30 16 drug record book.
11:31:30 17 Q. Yes.
11:31:31 18 A. So there was a section that
11:31:33 19 would say "received" and the nurse would sign
11:31:36 20 and date, and then when it became computerized,
11:31:42 21 the box of insulin would be scanned. It was
11:31:45 22 like a grocery scanner, and it would, you know,
11:31:50 23 give a little beep and then you knew you had it
11:31:52 24 signed in.
11:31:53 25 Q. And would that information
11:31:55 26 electronically be transmitted to the pharmacy?
11:31:58 27 A. Yes.
11:31:58 28 Q. So they could --
11:32:00 29 A. I believe so, yes.
11:32:00 30 Q. To the best of your
11:32:03 31 knowledge?
11:32:03 32 A. Uhm-hmm.

11:32:03 Q. Okay. You go on to say in
11:32:07 g.:
11:32:07 "The insulin is refrigerated.
11:32:09 Caressant Care had three
11:32:10 refrigerators, one of each of
11:32:12 Level 1 and Level 2 in their
11:32:15 respective medication rooms and
11:32:16 one in Section B in the room
11:32:17 right next to the medication
11:32:19 room, which is also locked."
11:32:24 I believe you indicated
11:32:25 yesterday that that was -- you referred to that
11:32:27 as the treatment room?
11:32:29 A. I called it the treatment
11:32:30 room, but the title on the door was the exam
11:32:32 room.
11:32:32 Q. On the drawing that we were
11:32:34 looking at?
11:32:35 A. Yes, uhm-hmm.
11:32:35 Q. Thank you:
11:32:37 "Section B also had a small
11:32:38 locked fridge strictly for
11:32:40 vaccine storage."
11:32:42 So in respect of insulin, was it
11:32:44 always stored in fridges in locked rooms?
11:32:48 A. Yes.
11:32:49 Q. Would there be a lock on the
11:32:52 fridge?
11:32:52 A. Not for the medication
11:32:55 fridge, no.
11:32:55 Q. And when you say that, it
11:32:59 begs the question, was there any other fridge

11:33:00 that would have been locked?
11:33:01 A. Well, the vaccine fridge was
11:33:04 locked.
11:33:04 Q. And why would that fridge be
11:33:06 locked versus the fridge where items such as
11:33:10 insulin are kept?
11:33:10 A. Well, we didn't want anyone
11:33:14 else -- we didn't want anything else to go into
11:33:17 that fridge. It was strictly to be for
11:33:19 vaccines, and the time that we used it most was
11:33:25 for flu season, to give that vaccination.
11:33:30 Q. And in the fridges in which
11:33:35 insulin is stored, are there any other things
11:33:37 stored in those fridges?
11:33:38 A. There would be some ginger
11:33:42 ale in there. What else did we have in there?
11:33:47 The --
11:33:47 Q. Is that for residents' use?
11:33:50 A. For residents' use. We would
11:33:52 give a supplement, resource 2.0, and there were
11:33:56 several other types of nutritional supplements
11:34:01 and they would be kept in there.
11:34:03 We gave medications with apple
11:34:10 sauce or pudding, and if it was an open jar of
11:34:15 apple sauce, then that would be kept in there.
11:34:19 Q. Now, when the insulin boxes
11:34:25 were put into the fridge, did they have
11:34:28 separate resident bins in the fridge like the
11:34:31 medication cart does?
11:34:34 A. No, they would be kind of
11:34:35 stacked in rows on the shelf.
11:34:37 Q. All right. And would they be

11:34:40 separated in any particular manner?
11:34:42 A. Not -- I think they usually
11:34:46 had an elastic around them, like, you know, if
11:34:49 it were two or three boxes, then they would
11:34:52 have an elastic around them, I believe.
11:34:54 Q. And by that do you mean if
11:34:56 there were two or three boxes for any
11:34:57 particular resident?
11:34:58 A. That's correct.
11:34:59 Q. And I think your affidavit
11:35:01 indicates that some residents may be on more
11:35:05 than one type of insulin?
11:35:06 A. That's correct.
11:35:07 Q. So in the fridge they may
11:35:11 have more than one, at any given time they may
11:35:14 have more than one box of insulin cartridges?
11:35:16 A. That's correct.
11:35:17 Q. And I think your evidence
11:35:19 just was that they may be elasticized together
11:35:22 in the fridge?
11:35:23 A. Uhm-hmm.
11:35:23 Q. Okay, thank you. You go on
11:35:28 to say that:
11:35:30 "The individual cartridges
11:35:34 [...]"
11:35:34 And this would be the cartridges
11:35:35 that contain the insulin; correct?
11:35:38 A. That's correct.
11:35:39 Q. "[...] do not have the
11:35:41 resident's name on it.
11:35:42 Caressant Care had a plastic
11:35:44 labeler which someone could use

11:35:46 1 to print the resident's name and
11:35:47 2 then put it on the pen."
11:35:51 3 In other words put the label on
11:35:52 4 the pen, not on the actual cartridge?
11:35:54 5 A. That's correct.
11:35:55 6 Q. "Or they could use masking
11:35:57 7 tape and put the resident's name
11:35:58 8 on it and then tape it to the
11:35:59 9 pen," again not the cartridge?
11:36:05 10 A. Yes.
11:36:05 11 Q. And you go on to say that
11:36:08 12 residents may in fact have brought their own
11:36:11 13 pen from home when they came to Caressant Care,
11:36:14 14 and I assume what you are saying there is some
11:36:16 15 residents may have had diabetes before they
11:36:18 16 came into the home?
11:36:19 17 A. Yes.
11:36:19 18 Q. And the pens that you are
11:36:21 19 talking about, are they supplied by the
11:36:23 20 pharmacy?
11:36:23 21 A. Yes, they would be.
11:36:26 22 Q. You state there:
11:36:32 23 "Each type of insulin usually
11:36:34 24 had its own colour band around
11:36:35 25 the cartridge. The insulin
11:36:38 26 itself could be a clear or a
11:36:40 27 milky colour."
11:36:42 28 Is that correct?
11:36:43 29 A. That's correct.
11:36:43 30 Q. And again, Commissioner, we
11:36:45 31 do have those different cartridges so you'll be
11:36:48 32 able to see that distinction when they are

entered through the nurse.

Now, if you, as a Registered Nurse, and I know that it has been some time, but if you had need to get a new cartridge for the pen, did you have to sign that you were taking the cartridge out of the box at all?

A. No, we had no such requirement.

Q. All right. And the cartridge itself you identify in number m.:

"The cartridges contain 3 millilitres."

Is that correct?

A. Yes.

Q. "There are 100 units per ml," we are going to do some math now, Commissioner, "and therefore each cartridge holds 300 units [of insulin]."

Is that correct?

A. Yes.

Q. "Each resident on insulin is prescribed insulin for a certain number of units, or a sliding scale of units, depending on their blood sugar measurement at the time of administration."

So for our benefit, can you just describe or just clarify what is meant by a sliding scale?

A. Well, the doctor would give some indication as to how many units were

needed if the resident's blood sugar was between this and that, and then so many units of insulin if the blood sugar was higher from this to that. And there might be three such doses listed.

Q. So for insulin that is prescribed on a sliding scale, does that require the blood sugars to then be taken before the insulin is given?

A. Yes, each time.

Q. Okay. And so again, it may just be a tad easier to see something in action, Commissioner, so if I can turn you to doc ID 11569. It is not in the affidavit. It is in the Overview Report.

It does refer to one of the victims, so I apologize to the victim's family, Clotilde Adriano, if they are watching, but educationally-wise I thought it might be beneficial to the Commission.

And if we could go to page number 9 of that document. Do you recognize what this document is, the type of document it is, Helen?

A. Yes.

Q. And what is this document?

A. This is a paper Medication Administration Record.

Q. Okay. And on the left-hand side, the left-hand column, without talking about what is there right now, what does that generally signify to the nursing staff?

11:40:17 A. Sorry, what are you referring to?
11:40:20 Q. Let's just talk the first one, "insulin, Novolin cc 30/70". What is "30/70"?
11:40:20 A. That is the type of insulin to be given.
11:40:28 Q. "45 u", what is that --
11:40:28 A. That is every morning.
11:40:30 Q. Just let me catch up. So "q am" means every morning?
11:40:33 A. Yes.
11:40:34 Q. And under "Hours" it says 07:30, what does that signify?
11:40:39 A. What type it should be given.
11:40:40 Q. Okay. And then there is an arrow beside the 07:30 going over to March 6th, 2007 and then from then on until the 23rd, what is that that we are saying?
11:40:41 A. There was a change in direction, I believe.
11:40:46 Q. All right, but what are we seeing in those boxes?
11:40:48 A. The signatures of the nurses who gave the medication.
11:40:50 Q. All right. So when you were on the paper medication administration system, they would have to actually initial every single time they gave this medication?
11:40:53 A. That's correct.
11:41:02 Q. And when you were on the paper, did that -- was that for all drugs that
11:41:05
11:41:07
11:41:09
11:41:10
11:41:12
11:41:13
11:41:16
11:41:17
11:41:19
11:41:23
11:41:26
11:41:28
11:41:28
11:41:29

were given to every resident?
A. Yes.
Q. So within their shift, they would have to not only give all of those drugs but initial each and every time that they were given on this type of a sheet per resident?
A. That's correct.
Q. Okay. And then, sorry, I interrupted you. Let's just go down to the second line, "Novolin 30/70, 40 u", so that is a different amount?
A. Yes.
Q. But same --
A. A decrease.
Q. Same insulin?
A. Same insulin.
Q. And it says "q pm" means what?
A. That means in the evening.
Q. And it identifies 16:30?
A. 4:30 in the afternoon, yes.
Q. And again, are those initials as to when, during that particular time frame, the insulin had been given?
A. That's correct.
Q. Now, I interrupted you because you were -- you started to say that there was a change. Can you explain what you mean by there was a change?
A. The "X," you know, to the right shows that it wasn't given on the 24th and 25th and so on.

11:42:51 Q. Yes?
11:42:51 A. And then if we look down on
11:42:54 the 24th at 7:30, this new change took place,
11:42:59 and if we look at the medication underneath,
11:43:03 that change took place on the 23rd at 16:30.
11:43:07 Q. So the Novolin that was being
11:43:15 given every morning between March the 6th and
11:43:22 March the 23rd, which was 45 units of Novolin
11:43:28 30/70, was changed towards the end of the month
11:43:29 to 40 units in the morning; is that correct?
11:43:32 A. That's correct.
11:43:35 Q. And similarly the 16:30 dose
11:43:38 was changed, if I'm reading this right, from 40
11:43:41 units to 20 units; is that correct?
11:43:43 A. Yes.
11:43:44 Q. Now, would these -- is this a
11:43:47 doctor's order?
11:43:48 A. Yes, the change wouldn't have
11:43:50 been made unless it was a doctor's order.
11:43:52 Q. All right. But this
11:43:53 particular sheet that we are looking at, is
11:43:56 that a doctor's order?
11:43:57 A. No, this is a Medication
11:43:59 Administration Record.
11:43:59 Q. All right. So there would be
11:44:00 a separate doctor's order for that change?
11:44:03 A. Yes.
11:44:04 Q. And then if we can just
11:44:06 scroll down a bit further, there's two lines
11:44:14 for 16:30 and 07:30 with no "X's" or no
11:44:22 slashes. And what would that signify to you?
11:44:27 A. Sorry, say this again?

11:44:29 Q. If you scroll down to the
11:44:30 last two entries, we now have "Novolin 30/70,
11:44:34 20 units p.m., 16:30 Novolin 30/70 30 units q
11:44:43 am", and those don't have a slash in them like
11:44:46 the ones above. So what does that mean --
11:44:47 A. The arrow indicates that it,
11:44:49 you know, started on the 29th.
11:44:55 Q. So this was another change?
11:44:57 A. Another change.
11:44:57 Q. All right. And then so in
11:45:00 the course of this month, there were two new
11:45:04 medication changes for insulin, actually four
11:45:09 if we count the two different times; correct?
11:45:12 A. Correct.
11:45:13 Q. And all of those changes
11:45:17 would have to be understood by the nursing
11:45:21 staff and then the correct dosage provided; is
11:45:25 that correct?
11:45:25 A. That's correct.
11:45:25 Q. All right, thank you.
11:45:28 So if we go back to your
11:45:44 affidavit, we were talking hypothetically that
11:45:51 you are inserting a cartridge, a new cartridge
11:45:55 into the pen, and then once -- sorry, at page
11:46:03 number 14, paragraph o. -- first of all, I'm
11:46:09 assuming you actually -- how do you actually
11:46:13 get the cartridge into the pen?
11:46:15 A. I believe you unscrew it,
11:46:17 snap the cartridge in and screw it back
11:46:19 together.
11:46:19 Q. Okay. And the pen, when you
11:46:22 do that, is there already a needle attached?

11:46:24 A. No, we had a box of needles
11:46:30 or tips and they would put a new tip on with
11:46:33 each administration.
11:46:36 Q. So each and every time that
11:46:40 injectable insulin is given, they would have to
11:46:43 insert a needle into the end of the cartridge?
11:46:46 A. That's right.
11:46:47 Q. Okay. Now, when you did
11:46:54 that, in number o. you say:
11:46:57 "In order to use the pen, you
11:46:58 would insert a needle and prime
11:47:00 it. Usually a drop or two.
11:47:03 Then you would dial up the dose
11:47:05 that was needed."
11:47:07 So what do you mean by priming?
11:47:09 A. You wanted to make sure that
11:47:12 the insulin would be measured accurately, so
11:47:17 the insulin had to be right into the needle and
11:47:20 into the barrel of the needle, so you would
11:47:22 prime it until you saw a little drop come out.
11:47:25 Q. And to prime it, just in the
11:47:29 medication room, over a sink, over a garbage,
11:47:32 or is there any --
11:47:34 A. They usually did that in the
11:47:35 medication room, I believe.
11:47:36 Q. Okay.
11:47:38 A. Or, you know, you could do it
11:47:39 on your treatment card over a Kleenex or a
11:47:45 piece of paper towel or whatever.
11:47:47 Q. You indicate that you needed
11:47:48 to, in that same paragraph:
11:47:52 "Then you would dial up the dose

11:47:53 that was needed."
11:47:54 What do you mean "dial up"?
11:47:57 A. There was an indicator on the pen as to how many units and you would twist the end until you got to the right number.
11:48:05 Q. So. For instance, for Ms. Adriano, if I needed 40 units, you are saying you would dial up to the number 40?
11:48:19 A. Yes.
11:48:19 Q. And when we are talking about 300 units in a pen, would you be able to decipher yourself without that counting mechanism what is 30 or 40 units?
11:48:34 A. No, you couldn't see that.
11:48:36 Q. All right, so --
11:48:36 A. Accurately enough.
11:48:37 Q. So it is the pen that actually allows you to be accurate as to the number of units you are about to administer?
11:48:44 A. That's correct.
11:48:45 Q. And then you go on to say:
11:48:52 "Once the insulin is injected
11:48:53 into the resident the dial goes
11:48:55 back to 0."
11:48:58 Now, before that, there is the whole thing you talked about this morning, the nurse would have to determine the right resident, the right dosage, the right delivery system, et cetera; is that correct?
11:49:08 A. That's correct.
11:49:09 Q. Now, when you say the dial goes back to zero, are you saying that it goes

11:49:15 1 up to 40 and then once it is into the resident,
11:49:19 2 it is right back to zero?
11:49:21 3 A. Once it is injected, yes, it
11:49:23 4 goes to zero.
11:49:23 5 Q. All right. You do
11:49:27 6 acknowledge at number q. that:
11:49:33 7 "Insulin is a medication that
11:49:34 8 can negatively impact a resident
11:49:36 9 if not given correctly."
11:49:39 10 Is that correct?
11:49:39 11 A. Yes.
11:49:40 12 Q. And then in number r. you
11:49:43 13 say:
11:49:43 14 "It was not typically a
11:49:44 15 requirement for insulin to have
11:49:45 16 another person check the dose
11:49:47 17 that was dialled up. Each nurse
11:49:50 18 was to be extra careful and
11:49:52 19 double-check that they dialled
11:49:53 20 correctly. That would mean that
11:49:57 21 the nurse would draw up the
11:49:59 22 dose, put the pen aside for a
11:50:00 23 minute or so and then look at it
11:50:02 24 again."
11:50:06 25 Why that process in terms of
11:50:08 26 putting the pen aside and then looking at it
11:50:10 27 again?
11:50:11 28 A. Just to make sure that they
11:50:14 29 were, you know, fully concentrated on the
11:50:17 30 dosage, that they wouldn't make an inadvertent
11:50:19 31 mistake.
11:50:19 32 Q. They wouldn't have another

11:50:24 nurse there, as I understand your evidence,
11:50:27 someone watching them and to whom they hand the
11:50:31 pen to say, have I dialled up 40 units?
11:50:34 A. They might, if they were
11:50:37 working in the same area, but that was highly
11:50:39 unlikely.
11:50:40 Q. So generally speaking, I
11:50:42 think your earlier evidence was that the RPNs
11:50:45 and the RNs were assigned their own block of
11:50:48 residents; is that correct?
11:50:49 A. That's correct, and they
11:50:50 would be, you know, somewhere down the hallway.
11:50:53 Q. And are insulin -- is insulin
11:50:57 generally given around meal times?
11:51:01 A. Yes. It would depend on what
11:51:05 type of insulin it was. The fast-acting
11:51:10 insulins we wanted given after meals to make
11:51:12 sure that the resident had eaten enough food to
11:51:19 use the insulin.
11:51:20 Q. And so let me ask you this
11:51:30 question. Can I take Mr. Smith's and Sally's
11:51:36 and Jane's pens and dial them all up all at
11:51:41 once and put them on my cart, so that when I
11:51:43 reach them, I can just give it to them?
11:51:45 A. That wasn't the process. You
11:51:50 would dial up at -- you know, you would park
11:51:56 your cart close to where the resident was and
11:51:58 then check your administration record for how
11:52:01 many units and then dial up.
11:52:04 Q. And then would I have to
11:52:09 repeat that for every one of my residents that
11:52:12 was on insulin?

11:52:13 A. That's correct.
11:52:13 Q. And not every long-term care resident is on insulin?
11:52:16 A. That's correct. Some might be on an oral hypoglyceamic.
11:52:17 Q. And that would be a pill form; correct?
11:52:24 A. A tablet, yes.
11:52:27 Q. A tablet. So in terms of if there was to be an independent double-check by another nursing staff, given who you had at -- the staffing levels you had at the home, where would the first nurse draw the second person from?
11:52:28 A. Well, if it was on day shift, it would be easiest to draw the Charge Nurse.
11:52:35 Q. So they would have to locate the Charge Nurse?
11:52:37 A. Uhm-hmm. She was usually at the desk, I would think.
11:52:42 Q. Now, if they were going to do that, would the Charge Nurse have to look at the Medication Administration Record and the pen?
11:52:45 A. She would have to go down and double-check that, yes.
11:52:49 Q. All right. And they would have to do that each and every time?
11:52:52 A. That's correct.
11:52:54 Q. All right. Now, in number t. you say:
11:52:58 "Nothing prevents a Registered

11:53:29 1 Nurse from dialling up more
11:53:30 2 insulin when he or she walks
11:53:32 3 away from the nurse that checked
11:53:33 4 it."
11:53:34 5 So if there was this independent
11:53:36 6 double-check, you are saying as soon as the
11:53:39 7 other nurse saw it, the nurse with the pen
11:53:42 8 could simply dial up more; is that correct?
11:53:45 9 A. Yes, I believe so.
11:53:48 10 Q. The mechanism at the time
11:53:51 11 didn't stop at 40 units; it could go upwards if
11:53:55 12 there was sufficient insulin in the cartridge?
11:53:58 13 A. That's correct.
11:53:58 14 Q. And then after that dose was
11:54:04 15 given, the only thing that would register would
11:54:06 16 be the number zero on the --
11:54:11 17 A. That's correct.
11:54:11 18 Q. You also indicate in number
11:54:11 19 u.:
11:54:19 20 "Insulin is not counted/traced
11:54:21 21 either at the Home."
11:54:23 22 Sorry, it says "either at the
11:54:25 23 home" and I think that is in error, it should
11:54:28 24 say "at the home."
11:54:30 25 So it was -- I think you said if
11:54:32 26 you got a new cartridge out of the fridge, you
11:54:35 27 wouldn't have to identify that on any
11:54:36 28 particular sheet; is that correct?
11:54:37 29 A. That's correct.
11:54:38 30 Q. And we have seen that there's
11:54:50 31 counts of other drugs, but nothing counted in
11:54:53 32 terms of insulin?

11:54:55 A. That's correct.
11:54:56 Q. Now, let's talk about you
11:55:00 have gone around and you have given most of
11:55:04 your doses, but you get to Ms. Adriano who
11:55:08 needs 40 units and it doesn't appear that there
11:55:13 is sufficient insulin to do that 40 units.
11:55:17 A. Uhm-hmm.
11:55:17 Q. You have indicated in number
11:55:19 v. of your affidavit:
11:55:21 "Hypothetically, if there is not
11:55:23 enough insulin left in the
11:55:24 cartridge to give the resident
11:55:26 the full dose, I would throw the
11:55:29 cartridge away. I wouldn't want
11:55:31 to inject a resident more than
11:55:33 once."
11:55:38 So it is not possible to have
11:55:43 one insulin cartridge and then insert another
11:55:46 and keep dialling up? You are saying it would
11:55:48 actually require two injections into the
11:55:51 resident, one to finish the first cartridge and
11:55:54 then the second to continue whatever dose you
11:55:56 needed?
11:55:59 A. I believe so. You had to
11:56:01 prime it in between, right, so I don't know.
11:56:09 When you talk to your nurses, that might be a
11:56:11 good question for them.
11:56:12 Q. All right. And we prefaced
11:56:13 the whole thing by saying this is your
11:56:16 understanding, so we appreciate that. That is
11:56:18 why the actual things will be going through the
11:56:21 nurses. You say:

11:56:24 1 "I would throw the cartridge
11:56:26 2 away. I wouldn't want to inject
11:56:28 3 a resident more than once.
11:56:29 4 Empty or near empty cartridges
11:56:31 5 are thrown in the non-controlled
11:56:33 6 drug destruction box which is
11:56:34 7 located under the sink in the
11:56:36 8 medication room. No one
11:56:38 9 counts," and we went over this
11:56:39 10 earlier, "what is thrown away in
11:56:41 11 the drug destruction box."
11:56:43 12 Is that your understanding?
11:56:44 13 A. Yes.
11:56:45 14 Q. Okay. You say:
11:56:47 15 "In addition, some nurses might
11:56:48 16 put the cartridges in the sharps
11:56:50 17 box. The sharps box, when full,
11:56:53 18 is stored in the locked room" in
11:56:57 19 the basement.
11:56:58 20 And we have gone over that this
11:56:59 21 morning; is that correct?
11:57:01 22 A. Yes.
11:57:01 23 Q. All right, and in paragraph
11:57:07 24 x. you say:
11:57:07 25 "We do not record when a
11:57:09 26 cartridge is thrown away. It is
11:57:10 27 true that someone could pocket
11:57:11 28 the cartridge."
11:57:14 29 A. Yes.
11:57:15 30 Q. So if someone has passed away
11:57:19 31 in the home with three cartridges left in the
11:57:22 32 fridge of insulin, is it your testimony that

11:57:26 1 those would be thrown in the non-controlled
11:57:28 2 drug destruction box or the sharps container;
11:57:32 3 is that correct?
11:57:32 4 A. Yes. The only time that it
11:57:37 5 might be reallocated to another resident is if
11:57:42 6 the Pharmacy Consultant happened to be there on
11:57:44 7 that day and she could make a new label, you
11:57:48 8 know, for the box, just a handwritten label,
11:57:52 9 but that didn't happen very often.
11:57:55 10 Q. Yes, okay, but other than
11:57:56 11 that, it would be the process -- you believe it
11:58:00 12 was the process you have described which was
11:58:02 13 the non-controlled drug destruction box or the
11:58:06 14 sharps container, and you indicated earlier
11:58:09 15 that when those things were thrown away, there
11:58:13 16 didn't need to be somebody there to sign; there
11:58:16 17 wasn't a double signing of it, is that correct?
11:58:18 18 A. Yes.
11:58:18 19 Q. And then when they were
11:58:19 20 actually denatured, there wasn't any count or
11:58:24 21 trace done of it at that point in time either?
11:58:27 22 A. Yes.
11:58:27 23 Q. And then finally at number z.
11:58:32 24 you say:
11:58:32 25 "The pharmacy does provide drug
11:58:34 26 utilization statistics. We
11:58:36 27 reviewed it yearly. Those
11:58:38 28 statistics were more focussed on
11:58:40 29 tranquilizers, pain medication,
11:58:43 30 psychotropics. I do not recall
11:58:46 31 any drug utilization statistics
11:58:48 32 re insulin other than perhaps

11:58:51 1 the percentage of residents
11:58:52 2 within Caressant Care on
11:58:54 3 insulin."
11:58:54 4 So how many residents you had,
11:58:56 5 is that what you mean by that?
11:58:57 6 A. Yes.
11:58:58 7 Q. Now, if someone was taking
11:59:06 8 small amounts of insulin from different pens,
11:59:10 9 from your experience would you be able to trace
11:59:12 10 that?
11:59:13 11 A. I don't believe so.
11:59:15 12 Q. All right. So, Commissioner,
11:59:19 13 that is the evidence so far on insulin. We'll
11:59:21 14 pick it up with the Registered Nurses that are
11:59:23 15 actually delivering the insulin.
11:59:25 16 So thank you, Helen, for helping
11:59:39 17 us understand some of the medication management
11:59:41 18 and insulin systems within the home.
11:59:43 19 What I want now to do is discuss
11:59:45 20 with you Elizabeth Wettlaufer. Now, you
11:59:51 21 described earlier the hiring process that you
11:59:55 22 undertook of Registered Nurses. Do you recall
11:59:57 23 that? That was last night, before we broke for
12:00:00 24 the day?
12:00:00 25 A. Yes.
12:00:00 26 Q. Okay. And you actually
12:00:04 27 interviewed Elizabeth Wettlaufer, your
12:00:06 28 affidavit indicates; is that true?
12:00:07 29 A. That is true.
12:00:08 30 Q. And what was she like at the
12:00:10 31 time that you interviewed her, if you can
12:00:12 32 recall?

12:00:13 A. Well, she seemed very nice
12:00:17 and pleasant. She spoke well. She looked
12:00:24 well. She seemed happy.
12:00:31 Q. And what would be the next
12:00:33 step in your process then regarding making sure
12:00:36 that Elizabeth Wettlaufer was qualified for
12:00:39 your home?
12:00:40 A. Well, I would have checked
12:00:43 her registration online with the College of
12:00:50 Nurses.
12:00:50 Q. Now, let me just stop you
12:00:52 there just a second because we'll see some
12:00:58 evidence later on in the Inquiry about a
12:01:01 website called "Find a Nurse," and was that
12:01:06 website available to you in 2007, do you know?
12:01:10 A. It might not have been. Then
12:01:15 she would have shown me her registration card.
12:01:17 Q. All right, but would you
12:01:20 check that with the College of Nurses?
12:01:21 A. No, I would check the date on
12:01:22 the registration card, and if it was good until
12:01:29 -- I forget what date it says, if it was
12:01:31 December or January, but then she would be
12:01:36 registered.
12:01:37 Q. Okay. Were you aware at that
12:01:39 point in time as to whether there was any
12:01:43 conditions of her registration?
12:01:45 A. No.
12:01:46 Q. All right. Now, in terms of
12:01:53 her references, let's first turn to her resumé.
12:02:00 She submitted a resumé to you, did she not?
12:02:03 A. Yes, she did.

12:02:05 Q. All right, let's just see
12:02:09 what that resumé says. If I can turn you,
12:02:11 Commissioner, to tab C, document 57084. And it
12:02:33 is the second document at tab C. Helen, are
12:02:37 you there? Have you found it?
12:02:39 A. Yes, I have found it.
12:02:44 Q. So just briefly, she
12:02:46 describes herself as working at Christian
12:02:51 Horizons:
12:02:51 "Job title - support worker: I
12:02:54 am part of a team which assists
12:02:56 five developmentally challenged
12:02:57 individuals who live together in
12:02:59 a group home. My duties include
12:03:01 administering medication and
12:03:03 assisting the individuals in all
12:03:05 aspects of their daily living
12:03:07 including bathing, personal
12:03:10 hygiene, food preparation and
12:03:12 clean up, laundry, and community
12:03:15 outings. I am also responsible
12:03:17 for coordinating training for
12:03:18 other staff members in the area
12:03:20 of medication administration and
12:03:22 for ensuring staff regularly
12:03:25 review medication procedures,
12:03:27 classifications and side
12:03:28 effects. Doing so, combined
12:03:30 with assisting the individuals
12:03:32 to learn how to perform aspects
12:03:34 of their own care has helped me
12:03:37 develop solid teaching skills.

12:03:41 1 As the health and safety
12:03:42 2 coordinator for our workplace I
12:03:45 3 perform regular safety
12:03:46 4 inspections of the group home
12:03:47 5 and monthly fire drills for the
12:03:49 6 staff and individuals. I have
12:03:51 7 also been responsible for
12:03:52 8 coordinating the finances of the
12:03:54 9 home and for developing personal
12:03:56 10 plans for some of the
12:03:57 11 individuals.
12:03:59 12 As part of a district wide team,
12:04:01 13 I am a member of a panel of
12:04:04 14 front line staff and management
12:04:05 15 who investigate allegations of
12:04:07 16 client abuse within the group
12:04:08 17 homes. I have demonstrated
12:04:11 18 interview skills as well as
12:04:13 19 maintaining a high level of
12:04:15 20 confidentiality while doing so.
12:04:18 21 I have developed a course in
12:04:20 22 proper lifting techniques. I
12:04:21 23 have taught this course to the
12:04:23 24 staff in all of the homes within
12:04:25 25 our district. I am also
12:04:26 26 available to assist with
12:04:27 27 addressing any safe lifting
12:04:29 28 issues within the district."
12:04:32 29 So that is how she presented
12:04:33 30 herself to you?
12:04:34 31 A. Yes, she did.
12:04:36 32 Q. And I won't turn you there,

12:04:38 1 but it is in evidence at document 57086. You
12:04:44 2 received a reference letter from Christian
12:04:46 3 Horizons?
12:04:46 4 A. Yes, I did.
12:04:47 5 Q. Did you speak to anyone at
12:04:49 6 Christian Horizons?
12:04:51 7 A. Yes, I called this Mark
12:05:00 8 Lambley and he was supportive of Bethe and
12:05:04 9 hoped she would do well for us. He seemed to
12:05:07 10 be very encouraging.
12:05:09 11 Q. Did you decide then to hire
12:05:17 12 her?
12:05:17 13 A. Yes, I thought we were lucky
12:05:20 14 to have her come through the door.
12:05:21 15 Q. Did she receive orientation
12:05:25 16 at the home?
12:05:26 17 A. Yes, she did.
12:05:28 18 Q. And what type of orientation
12:05:29 19 would she have received?
12:05:30 20 A. She would have been scheduled
12:05:34 21 to spend a day with Marie Buckrell, who was the
12:05:42 22 Assistant Director of Nursing at the time and
12:05:45 23 did the education for the home.
12:05:50 24 Q. And if I can turn you to tab
12:05:57 25 Exhibit "D" of your affidavit, document 57094.
12:06:25 26 What is this document?
12:06:25 27 A. This is a General Orientation
12:06:30 28 for all employees in the nursing department for
12:06:35 29 Bethe Wettlaufer.
12:06:36 30 Q. And the instructor initials,
12:06:39 31 I think you indicated that that was Marie
12:06:42 32 Buckrell?

12:06:42 A. That's correct.
12:06:42 Q. And this says "General Orientation - All Employees." Was there also any orientation given to registered staff, or is this the extent in 2007?
12:06:45 12:06:49 12:06:54
12:06:56 A. I can't recall.
12:06:56
12:07:02 Q. Okay. So if we go down, scroll down to the bottom, it identifies that Ms. Wettlaufer has been oriented on the abuse policy and violence in the workplace?
12:07:02 12:07:04 12:07:10 12:07:14
12:07:17 A. That's correct.
12:07:17
12:07:17 Q. Now, it does say "abuse policy," and someone has added "violence in the workplace"; do you know if that was added at the time or subsequently? Are you aware?
12:07:17 12:07:21 12:07:24 12:07:26
12:07:29 A. I believe that is Marie Buckrell's writing on it, so I believe it was added at the time.
12:07:29 12:07:31 12:07:33
12:07:34 Q. Now, I understand from paragraph 80 of your affidavit that Elizabeth Wettlaufer initially was hired to work all shifts; is that correct?
12:07:34 12:07:40 12:07:46 12:07:47
12:07:49 A. That's correct.
12:07:49
12:07:50 Q. And that was a part-time position?
12:07:50 12:07:52
12:07:53 A. Yes.
12:07:53
12:07:53 Q. And then paragraph 80 indicates that you believe she went full-time evenings and nights in Section B?
12:07:53 12:07:56 12:08:00
12:08:02 A. Yes.
12:08:02
12:08:05 Q. And then full-time evening and nights in Section A?
12:08:05 12:08:07

12:08:08 A. Yes.
12:08:09 Q. All right. Now, we have
12:08:12 heard some discussion regarding staffing levels
12:08:15 in long-term care and in Caressant Care. So we
12:08:22 have endeavoured, Commissioner, to attempt to
12:08:24 make this slightly easier for everyone, and if
12:08:34 you can just give me a moment, if I can turn
12:08:41 you to tab E of your affidavit, document number
12:08:55 72518.
12:08:59 A. Yes.
12:08:59 Q. And if we can rotate that,
12:09:13 please. Now, I understand from your affidavit
12:09:20 you are retired now; is that correct?
12:09:23 A. That's correct.
12:09:24 Q. And this document has been
12:09:26 developed for the benefit of the Commission and
12:09:28 the Commissioner by the current staff at
12:09:32 Caressant Care; is that correct?
12:09:34 A. Yes.
12:09:35 Q. But to the best of your
12:09:37 recollection, does this adequately portray the
12:09:41 staffing levels and changes during the period
12:09:45 that Elizabeth Wettlaufer was with Caressant
12:09:50 Care?
12:09:50 A. Yes.
12:09:50 Q. So we'll just take a few
12:09:52 minutes, Commissioner, to look at this
12:09:56 document.
12:09:56 In 2007, when she starts, you
12:10:01 indicated that she could be on all three
12:10:03 shifts; is that right?
12:10:04 A. That's correct.

12:10:05 Q. And part-time?
12:10:06 A. Yes.
12:10:06 Q. So if we look at 2007, the
12:10:15 shift, it has "D," "E" and "N." What do you
12:10:21 understand those to mean?
12:10:23 A. The "D" is for days, "E" is
12:10:25 for evenings, and "N" is for nights.
12:10:29 Q. And then there is a tab up at
12:10:31 the top, the first box says "RN," that would be
12:10:34 Registered Nurses?
12:10:34 A. Yes.
12:10:34 Q. Now, this chart is a little
12:10:42 skewed off, but my understanding, the first row
12:10:45 of numbers, you can't really see it,
12:10:47 Commissioner, but it is bolded. Under the 3,
12:10:51 2, 1, what did you understand that to be on
12:10:57 days 3 --
12:10:58 A. That is the total number of
12:11:00 Registered Nurses on that shift.
12:11:02 Q. Okay. And then across from
12:11:05 the 3 is 1, 1 and 1?
12:11:10 A. So there was 1 Registered
12:11:13 Nurse on Section B, one on Level 1 and one on
12:11:18 Level 2.
12:11:18 Q. Thank you. And then if we
12:11:21 keep on days and go over to RPNs?
12:11:26 A. There were two RPNs in
12:11:29 Section B.
12:11:33 Q. And there were 18 PSWs then,
12:11:36 is that correct, altogether on day shift?
12:11:39 A. Correct.
12:11:40 Q. If you go over to PSWs?

12:11:42 A. Yes.
12:11:42 Q. Okay.
12:11:43 A. In total, uhm-hmm.
12:11:44 Q. So if we go down to evenings
12:11:47 and nights, on evenings it identifies that you
12:11:52 would have two RNs and two RPNs working as of
12:11:59 2007?
12:11:59 A. Yes.
12:12:00 Q. And then nights, you had one
12:12:02 RN in the building and one RPN; is that
12:12:05 correct?
12:12:05 A. That's correct.
12:12:06 Q. Now, I hate to do math but we
12:12:10 are going to do a bit of math. Refresh our
12:12:13 memory, if you can, in Section B the number of
12:12:18 residents, approximately?
12:12:25 A. In 2007 there would be 90, at
12:12:29 least 90, maybe 95, I don't know.
12:12:31 Q. Approximately 90 to 95?
12:12:35 A. Yes.
12:12:35 Q. Level 1?
12:12:37 A. Oh, and yeah, it went up to
12:12:39 99, but I think in 2007 it wasn't, you know,
12:12:42 that full. That happened when Brenda was
12:12:47 there, I think, and she didn't come until
12:12:49 later.
12:12:52 Q. So approximately in the 90s
12:12:56 somewhere?
12:12:56 A. Uhm-hmm.
12:12:57 Q. And Level 1?
12:12:58 A. Again, it is just a guess, 32
12:13:03 or 34.

12:13:05 Q. All right. Somewhere between
12:13:08 30 and 35; is that accurate?
12:13:12 A. Yes. Well, we got the
12:13:14 licences at the same time, so it would be
12:13:15 either 30 or 32.
12:13:17 Q. Okay. And Level 2?
12:13:19 A. The same.
12:13:20 Q. So when there is a day shift,
12:13:28 you would have -- in 2007, you would have one
12:13:35 RN and two RPNs in Section B, the larger
12:13:41 portion of the home; am I reading that
12:13:43 correctly?
12:13:43 A. That's correct.
12:13:44 Q. Now, if I'm wrong, make sure
12:13:46 that you tell me. I can take it, okay.
12:13:48 And on evenings, you would have
12:13:53 one RN in Section B and then one RN -- now,
12:13:59 would that be looking over both Levels 1 and 2?
12:14:03 A. No, on Level 1 we would have
12:14:05 the RN, and on Level 2 we would have the RPN.
12:14:12 Q. Okay. And those individuals
12:14:18 would each be taking care of 30 to -- around 30
12:14:23 to 32 residents?
12:14:24 A. That's correct.
12:14:25 Q. All right. And then on
12:14:27 nights, in Section B the nurse, the RN would be
12:14:33 responsible for all 99 -- 90 to 99 residents?
12:14:42 A. Yes.
12:14:43 Q. And then the RPN would be
12:14:44 responsible -- now, it has the RPN under
12:14:46 Section B, but where would the RPN actually be
12:14:50 working?

12:14:50 A. The RPN would float between
12:14:54 Levels 1 and 2.
12:14:55 Q. All right. So one RN for
12:15:00 approximately 90 to 99 residents and one RPN
12:15:06 for approximately 60 to 64 residents?
12:15:09 A. That's correct.
12:15:10 Q. And then the next portion of
12:15:24 the chart is 2012, and we'll just talk about
12:15:30 the RNs for a minute, just to make it a little
12:15:33 easier. From my review of this document, did
12:15:36 your RN complement ever change between 2007 and
12:15:41 2014 on those shifts?
12:15:43 A. No.
12:15:44 Q. And the RPN complement, did
12:15:50 it remain the same until 2014?
12:15:52 A. Yes.
12:15:54 Q. And then what happened in
12:15:56 2014?
12:15:56 A. There were -- in 2014?
12:16:11 Q. Just in terms of --
12:16:12 A. One on Section B, it looks
12:16:15 like, one on Level 1 and one on Level 2.
12:16:19 Q. So you were able to hire
12:16:20 another RPN?
12:16:21 A. Yes.
12:16:21 Q. All right. And then the
12:16:23 chart on the right indicates that the PSW
12:16:26 complement has essentially, the total has
12:16:33 stayed the same but the allocation has changed?
12:16:35 A. Changed, yes.
12:16:37 Q. Now, again, this doesn't
12:16:39 include nursing managers and students. It is a

12:16:41 1 general chart of the registered staff doing the
12:16:45 2 direct care; is that correct?
12:16:46 3 A. Yes.
12:16:47 4 Q. Okay. One thing that I
12:16:54 5 should clear up from yesterday, we were looking
12:16:56 6 at drawings of the home, and Caressant Care,
12:17:02 7 was it all private rooms?
12:17:03 8 A. No, in Section B there were
12:17:08 9 private rooms, semi-privates with two people to
12:17:12 10 a room, and ward rooms with four people to a
12:17:17 11 room.
12:17:17 12 Q. So it is not as easy to just
12:17:18 13 count out the number of rooms and know how many
12:17:20 14 residents are being cared for?
12:17:22 15 A. No, you had to know which
12:17:24 16 rooms had the number of people.
12:17:26 17 Q. And so when the nurse is
12:17:31 18 administering medication and the individual
12:17:33 19 happens to be in a bed in the ward room, how
12:17:37 20 would they know which bed which resident is in?
12:17:41 21 A. Well, we had the names on the
12:17:45 22 beds and the room number and the bed number and
12:17:51 23 the doctor's name on the bed label.
12:17:57 24 Q. Would it be identified on the
12:18:00 25 Medication Administration Record as well?
12:18:01 26 A. Yes, the room number would be
12:18:03 27 there as well.
12:18:04 28 Q. Would the bed number be there
12:18:10 29 as well?
12:18:11 30 A. Yes. It wouldn't say room --
12:18:16 31 it would just say "room," but you could write
12:18:19 32 in the bed number, just a little 2 or a 1 or a

12:18:26 4, and we did that.
12:18:31 Q. Now, I don't want to get into
12:18:33 the discussions about how things are funded in
12:18:37 long-term care or how staffing may have changed
12:18:40 in combination with funding, but what I do want
12:18:43 to ask you is we heard testimony yesterday
12:18:47 about how the acuity level of residents could
12:18:51 impact the level of funding that you would
12:18:54 receive.
12:18:55 In your experience, and it is a
12:18:57 long experience, so let's limit it to the last
12:19:00 decade that you were there, 2007 or so to 2017,
12:19:06 did you see a difference in the acuity level of
12:19:09 residents?
12:19:10 A. Yes, certainly. Residents
12:19:14 came in frailer, usually in a wheelchair. We
12:19:25 also had a lot of residents with behaviours.
12:19:31 Q. Do you mean more residents
12:19:32 with behaviours?
12:19:33 A. Yes. They might have managed
12:19:37 in the community, you know, for awhile living
12:19:40 in a group home, but their health or their
12:19:43 condition changed so that they needed more
12:19:53 care.
12:19:54 Q. All right, thank you, Helen.
12:19:59 Now, I want to talk about
12:20:05 Elizabeth Wettlaufer's performance in the early
12:20:07 years. From my review of your affidavit, it
12:20:11 indicates that by the end of 2008 she had one
12:20:15 counselling for absenteeism and four medication
12:20:19 errors.
12:20:22 Now, I want to look at the

12:20:25 1 medication errors that she was committing at
12:20:29 2 that point in time or purported to have
12:20:32 3 committed.
12:20:32 4 If I can turn you to tab FF of
12:20:35 5 your affidavit. Sorry, document 16915. And I
12:21:08 6 think we have looked at this type of document
12:21:13 7 before. What is the error in this particular
12:21:18 8 case?
12:21:18 9 A. It is hard to say because
12:21:21 10 there is nothing documented on it, but the
12:21:30 11 Lasix 40 mg. was not in the strip pack at 8
12:21:35 12 o'clock.
12:21:36 13 Q. All right. And when you say
12:21:39 14 Lasix, the brief description says "no
12:21:44 15 Furosemide"; is that correct?
12:21:46 16 A. Yes, that is one and the
12:21:47 17 same.
12:21:47 18 Q. One and the same. So there
12:21:50 19 is no indication -- what do you mean by there
12:21:52 20 is no indication of what the error was?
12:21:53 21 A. Well, in my opinion there
12:21:59 22 didn't need to be an error, but I think this is
12:22:08 23 Marie's writing at the top here and --
12:22:13 24 Q. Now when you say that, it is
12:22:16 25 at the top right-hand side, it says "Bethe W."?
12:22:19 26 A. Yes.
12:22:19 27 Q. Was this located in her
12:22:21 28 employment file?
12:22:21 29 A. Yes.
12:22:22 30 Q. And when would you normally
12:22:24 31 put something like this in an employee's
12:22:27 32 employment file?

12:22:28 A. When the incident happened,
12:22:33 and I believe Marie must have thought that
12:22:38 Bethe was involved in some way, so whether she
12:22:40 was working nights and didn't check the
12:22:45 cycle-fill thoroughly or if there was an order
12:22:47 that was missed and it wasn't processed
12:22:51 properly.
12:22:55 Q. And this is -- we looked at a
12:22:59 medication error earlier today where the pill
12:23:04 was left in the narcotic card, and this is a
12:23:07 medication error where there was none found in
12:23:10 the cycle pack. Is that a different type of
12:23:13 medication error?
12:23:16 A. Well, one is administration,
12:23:20 and it is hard to say what this one is because
12:23:24 there is no documentation on it.
12:23:29 Q. Okay, thank you. Now, is
12:23:31 this form that we are looking at, is this a
12:23:33 computerized form?
12:23:35 A. Yes.
12:23:35 Q. And is it an internal form?
12:23:38 A. Yes, it is an internal
12:23:42 Resident Incident Report.
12:23:46 Q. And at this point in time
12:23:49 when this form would be filled out on your
12:23:51 computer system, would the form be provided in
12:23:56 any manner, in any way to the pharmacy?
12:23:59 A. No.
12:24:00 Q. Under what circumstances
12:24:03 would you report a medication error to the
12:24:06 pharmacy?
12:24:06 A. If it was a pharmacy error,

12:24:12 1 if there was a mistake in the medication that
12:24:15 2 was received, not the right strength, for
12:24:21 3 instance.
12:24:21 4 Q. So if the mistake could be
12:24:25 5 attributed to the pharmacy; is that correct?
12:24:28 6 A. That's correct.
12:24:29 7 Q. And those are the incidents
12:24:30 8 that you would provide to the pharmacy?
12:24:34 9 A. Yes.
12:24:35 10 Q. And did that process ever
12:24:36 11 change?
12:24:37 12 A. That was changing when I left
12:24:40 13 Caressant Care.
12:24:41 14 Q. And what about the process
12:24:43 15 was changing?
12:24:44 16 A. We wanted the nurses to
12:24:51 17 document on this form and also fill in the
12:24:55 18 electronic form on their computer to go to
12:24:58 19 Medical Pharmacy.
12:24:59 20 Q. So you would have an internal
12:25:04 21 form and then you wanted the nurses to fill out
12:25:08 22 another form on the computer system that would
12:25:11 23 go straight to the pharmacy?
12:25:13 24 A. That's correct.
12:25:14 25 Q. For all errors? For all
12:25:17 26 medication errors?
12:25:18 27 A. Correct.
12:25:18 28 Q. What would be the purpose of
12:25:20 29 letting the pharmacy know all medication
12:25:23 30 errors?
12:25:23 31 A. I think they were going to
12:25:25 32 audit it for Caressant Care.

12:25:29 Q. Is this something that, to
12:25:31 your experience, was changing in the industry
12:25:34 or had changed in the industry and Caressant
12:25:36 Care was catching up, or are you aware?
12:25:38 A. I believe that was the
12:25:40 reason.
12:25:41 Q. Which one; that it was a
12:25:43 change or that you were catching up?
12:25:45 A. That we were catching up,
12:25:49 probably.
12:25:50 Q. Okay. Now, if I can turn you
12:25:57 to the incident that happened on March 24th,
12:26:04 2008, which is document 16909. Let me just
12:26:18 find it, Commissioner.
12:26:26 Okay, I just have to find it in
12:26:39 my own book here. Here it is.
12:26:50 I just lost my concentration for
12:26:57 a minute there, Commissioner. Just --
12:26:59 THE COMMISSIONER: It is no
12:27:00 problem. You are looking for
12:27:01 document 16909, March 24, '08,
12:27:06 critical incident.
12:27:12 MS. HEWITT: I apologize again.
12:27:23 THE COMMISSIONER: Not at all.
12:27:24 Is it HH?
12:27:27 BY MS. HEWITT:
12:27:27 Q. Yes. Mr. Sandler was just
12:27:34 asking me if I was leaving out the error on
12:27:35 March the 23rd, 2008, but that is the one I
12:27:38 referred to this morning when I was giving
12:27:40 examples, so I did leave it out in sequence.
12:27:44 So if I can go then to this

12:27:48 1 document, 16909. Is this another medication
12:27:55 2 error, Helen? Sorry, yes, tab HH.
12:28:04 3 A. Yes, it is.
12:28:05 4 Q. All right. Now, I can't read
12:28:10 5 from mine because mine has got some names in
12:28:13 6 it, and I do want to caution you as well,
12:28:16 7 Helen. I cautioned Brenda. You know the
12:28:19 8 residents very well that are named in some of
12:28:23 9 these documents. I know them only because I
12:28:26 10 have read the documents. At the Commission we
12:28:27 11 are not talking about any residents by their
12:28:29 12 first name or first and last name. Generally
12:28:31 13 speaking, we are not even talking about their
12:28:35 14 initials. We are simply talking about "the
12:28:38 15 resident," okay?
12:28:39 16 A. Yes.
12:28:39 17 Q. So we do have initials on
12:28:42 18 some of these documents but it says:
12:28:45 19 "[The resident] reported that
12:28:51 20 she had not received her HS
12:28:52 21 insulin [...]"
12:28:55 22 I think you said that is
12:28:57 23 bedtime; is that correct?
12:28:57 24 A. Yes.
12:28:58 25 Q. "[...] @ 0005 hour. Called
12:29:07 26 1500-23-hr RN [...]"
12:29:08 27 What does that mean ?
12:29:09 28 A. The 3:00 to 11:00 RN.
12:29:11 29 Q. "[...] @ 0010 hr who said
12:29:19 30 that she gave [the Resident]
12:29:21 31 insulin. Called again @ 0020 hr
12:29:23 32 where RN stated that 'maybe I

didn't give it' after [resident] insisted that she hadn't had it."

Do you see that document?

A. Yes.

Q. All right. It goes on to say that the blood sugar of the resident was 17.2 that night.

Now, if insulin isn't given to a diabetic, what happens with the blood sugars?

A. The blood sugar rises.

Q. All right. And are you able to comment in your experience on whether 17.2 is normal blood sugar, high, low?

A. It is quite high. This resident, you know, had a higher blood sugar than most residents as a rule.

Q. And it appears that this resident was capable enough to identify to the nurse herself that she hadn't been given her insulin?

A. That's correct.

Q. And my understanding from your affidavit is there were actually two medication errors on March the 24th, and the second one is the next document in that tab, document 16908. And this is actually Wayne Hedges. So, Commissioner, we haven't redacted the document because Mr. Hedges is one of the victims.

It says:

"March 24, 2008."

Under "Description":
"Notified by Res 3-1 that she,"
and we believe that to be an
error in terms of gender, "had
not received HS insulin.
1500-2300 hour RN telephoned at
home and confirmed that Wayne's
insulin had not been given."
Do you see that?
A. Yes.
Q. And was it your understanding that that RN was Elizabeth Wettlaufer?
A. Yes.
Q. And what is your understanding as to what happened then on March 24th, without using the other resident's name?
A. I believe that the RN working the night shift realized that there was another resident on that wing that might not have got his insulin, so she checked his insulin -- or his blood sugar level, rather, and noted that it was high and then called Bethe again to ask her, you know, are you sure that you gave the insulin because the first resident said she didn't have it and now I'm finding this high blood sugar for this resident.
Q. All right. And this incident report indicates that Mr. Hedges was "observed throughout shift after [being] given HS insulin," so this would be by the nurse that discovered it?
A. Yes.

12:32:55 Q. "For blood sugar of over 26," so would that be high?
12:33:03 A. Yes.
12:33:04 Q. And it indicates that again this particular resident was capable enough to identify to the nurse on staff at that point in time that he had not been given his insulin?
12:33:20 A. I don't know if that is true. I think Lois determined that he didn't have his insulin. You know, I don't know what his condition was at this time.
12:33:35 Q. All right, so maybe we have got this wrong. It says notified by resident 3-1 that she had not been given her insulin?
12:33:44 A. So that was the first one.
12:33:45 Q. So that was the first one who was a female resident, okay, thank you very much. Now, the writing on the top right-hand side of this document, whose handwriting is that?
12:33:59 A. That is my writing.
12:34:00 Q. And what does it say?
12:34:02 A. It says that I:
12:34:11 "Spoke to Bethe April 7/08 at
12:34:15 1607. To remedy this she is
12:34:17 taking med cards for insulin and
12:34:19 putting on top of med cart. I
12:34:22 asked to use the MAR as her
12:34:24 Bible signing as you go, and you
12:34:27 would realize potential
12:34:27 omissions."
12:34:30 Q. So this wasn't an incident

12:34:32 1 where somebody -- it appears it wasn't an
12:34:34 2 incident where someone got too much insulin; it
12:34:36 3 was insulin was missed?
12:34:37 4 A. That's correct.
12:34:38 5 Q. So let's just unpack it a
12:34:40 6 bit. Are you okay to continue?
12:34:41 7 A. Yes, I am.
12:34:42 8 Q. Okay, so let's just unpack it
12:34:44 9 a bit. What are you talking about when you say
12:34:49 10 -- sorry, my eyesight is not as good these
12:34:53 11 days:
12:34:53 12 "To remedy this she is taking
12:34:55 13 med cards for insulin and
12:34:57 14 putting on top of med cart. I
12:34:59 15 asked her to use MAR as her
12:35:01 16 Bible."
12:35:05 17 Could you explain what you mean
12:35:06 18 by that?
12:35:07 19 A. We had a little box in the
12:35:08 20 med room that had the times of administration
12:35:15 21 on a tab, so morning, noon, afternoon and
12:35:24 22 evening, and the insulin due for those
12:35:28 23 residents would be written on a little one-inch
12:35:33 24 card or so, and it would have the resident's
12:35:36 25 name, the doctor's name, the type of insulin,
12:35:41 26 the dosage and the doctor's name, if I haven't
12:35:51 27 mentioned that already.
12:35:52 28 Q. Uhm-hmm.
12:35:55 29 A. And the nurse for that time
12:35:57 30 of administration would pull those cards out
12:35:59 31 and it would be a guide to her as to what
12:36:03 32 insulin pens to get ready.

12:36:05 Q. Okay. And was that in
12:36:08 substitution of using the Medication
12:36:11 Administration Record?
12:36:11 A. It was in addition to, and it
12:36:16 was a process left over from the carded system
12:36:21 that, you know, we didn't really think about at
12:36:24 the time, and so I discussed it either with the
12:36:29 Nurse Consultant or the Pharmacy Consultant and
12:36:31 we got rid of those cards altogether.
12:36:34 Q. And what do you understand
12:36:40 Ms. Wettlaufer to have done or have not done
12:36:42 with this box of cards?
12:36:44 A. I believed that she forgot to
12:36:49 look or get those cards out and that she didn't
12:36:53 put him -- put them on her cart to remind her
12:36:57 to give insulin and that she didn't use her MAR
12:37:04 at all.
12:37:15 Q. So was Elizabeth Wettlaufer
12:37:17 then disciplined for this particular incident
12:37:21 or these two incidents together?
12:37:22 A. No, she was just counselled.
12:37:24 Q. Now, while we are talking
12:37:25 about counselling, in the sense of the union,
12:37:27 are they able to grieve a counselling?
12:37:29 A. No.
12:37:29 Q. Okay. And so what -- and it
12:37:38 is hard to go back. Hindsight is always,
12:37:41 unlike me, perfect 20/20 vision, but what would
12:37:45 your thinking at this point in time be, if you
12:37:49 can recall, as to how these med errors were
12:37:53 being dealt with?
12:37:54 A. I think, you know, it could

12:37:59 1 be very busy on evening shift and that she just
12:38:04 2 honestly forgot.
12:38:04 3 Q. Did you have any indication
12:38:08 4 at this point in time that she was harming any
12:38:10 5 residents?
12:38:11 6 A. No.
12:38:11 7 Q. Did you ever have any
12:38:13 8 indication at any point in time that she was
12:38:16 9 intentionally harming residents?
12:38:18 10 A. No. I realize now that this
12:38:21 11 was a diversion and it is unfortunate that we
12:38:25 12 didn't recognize that.
12:38:26 13 Q. And what do you mean "a
12:38:31 14 diversion"?
12:38:32 15 A. I believe, you know, that she
12:38:35 16 was not giving insulin so that she could use it
12:38:36 17 for someone else.
12:38:37 18 Q. Okay, thank you.
12:38:38 19 Now we are going to go on to a
12:38:45 20 different area. Are you all right, Helen?
12:38:48 21 A. I'll try to be.
12:38:54 22 MS. HEWITT: Do you want to take
12:38:55 23 the lunch break a bit early,
12:38:57 24 Commissioner?
12:38:58 25 THE COMMISSIONER: Let's just --
12:38:59 26 that is what I am wondering.
12:39:00 27 What is your next area?
12:39:01 28 MS. HEWITT: I am going to deal
12:39:02 29 with a Performance Appraisal
12:39:05 30 that was done later this same
12:39:06 31 year.
12:39:07 32 THE COMMISSIONER: And --

MS. HEWITT: It won't take very long, so if Helen is up for it, we can do it, but --
THE WITNESS: That is fine.
BY MS. HEWITT:
Q. Are you up for it? Okay.
So there is a performance -- let me ask who was responsible, first of all, for Performance Appraisals?
A. I was responsible for the Registered Nurses.
Q. All right. And that would include, after she was hired, Elizabeth Wettlaufer?
A. That's correct.
Q. And my understanding from a review of the employment file is that there was an Employee Performance Appraisal in 2008, on December 17th 2008; is that your recollection?
A. Yes.
Q. So, Commissioner, if we could turn to tab F, which is document number 16903. Whose handwriting is on this first page, Helen?
A. That is my handwriting.
Q. So I want to scroll first, Amanda, to page number 4.
My understanding, Helen, is you used a system of numerical rating of 1 to 4?
A. That's correct.
Q. And I just wanted to show what that rating meant. So 4 was good, it was commendable?

12:40:48 A. Yes.
12:40:49 Q. And then competent at 3,
12:40:52 provisional at 2, and poor at 1?
12:40:55 A. Yes.
12:40:56 Q. And those are the definitions
12:40:58 that you would work with at the time?
12:41:00 A. Yes.
12:41:00 Q. All right. So if we can go
12:41:02 back to page number 1, Amanda, please.
12:41:06 So in terms of your process,
12:41:19 what would you look at in order to form the
12:41:22 opinion that you refer in the Performance
12:41:28 Appraisals? What would be your process?
12:41:30 A. Well, I used to ask for other
12:41:35 nurses' opinions. I don't know if I did it in
12:41:40 2013. I don't think I did. I think I just,
12:41:46 you know, talked with the other managers and if
12:41:50 they had any concerns, you know, I would jot
12:41:53 that down.
12:41:53 Q. And we saw in the earlier
12:41:59 remarks that I made in the Commission that
12:42:01 Christian Horizons had a Performance Appraisal
12:42:05 process that allowed for a 360 review; in other
12:42:08 words, peers reviewed others. Did you ever
12:42:12 have a 360 review process or anything like that
12:42:15 within Caressant Care?
12:42:19 A. Well, we did -- I did that in
12:42:21 the beginning when the nurses weren't quite as
12:42:24 busy and I would, you know, just write out
12:42:26 everybody's name and pass out the form to the
12:42:30 RNs and ask them for a few comments on each of
12:42:34 their co-workers.

12:42:37 1 Q. Would they all be on one
12:42:39 2 sheet or would they be separate sheets?
12:42:42 3 A. They would be separate sheets
12:42:43 4 for each RN I was asking.
12:42:46 5 Q. All right. And then did that
12:42:49 6 process -- you said you "used to," did that
12:42:52 7 process drop off?
12:42:52 8 A. Yes. The Registered Nurses
12:42:58 9 felt they were too busy and didn't want to take
12:43:00 10 part in the process.
12:43:01 11 Q. And you didn't have any
12:43:02 12 corporate policy or home-based actual written
12:43:06 13 policy for those types of reviews?
12:43:08 14 A. Not that I am aware, no.
12:43:11 15 Q. For 360 reviews, okay.
12:43:13 16 And just to go through a couple
12:43:14 17 of things on your appraisal of Elizabeth
12:43:17 18 Wettlaufer, and this is into her first year and
12:43:19 19 a half. Under "Medication administration
12:43:21 20 skills," it says the "Appraisers rating"; is
12:43:26 21 that you?
12:43:26 22 A. Yes.
12:43:26 23 Q. And it says 2.5, and I'll
12:43:29 24 flip for you so nobody has to, 2 is provisional
12:43:32 25 and 3 is competent, and so you were giving her
12:43:37 26 a mid-mark on medication administration?
12:43:39 27 A. Yes.
12:43:40 28 Q. And then it says "Staff
12:43:41 29 rating." Do they actually give themselves a
12:43:44 30 rating as well?
12:43:45 31 A. Yes, they would get the form
12:43:47 32 first and rate themselves first, and then I

would rate them. And then we would get together and decide on the agreed rating.

Q. All right. So at that point in time the rating stayed at 2.5?

A. Yes.

Q. And what did that mean to you in terms of rating somebody 2.5 on medication administration skills?

A. That she needed to improve.

Q. Okay. Under the second one it says "Knows residents well," but I'll go to the fourth bullet point there, "Effective supervision of others." She actually gave herself a 2, if I'm reading this form right; is that correct?

A. I think I did that writing. I think maybe she didn't fill it out, and -- because that is my writing as well. So I would ask her, what would you give yourself for medication administration, what would you give yourself for effective supervision of others.

Q. But she is telling you she would actually rate herself as a 2?

A. Yes.

Q. And you are writing it down?

A. Yes.

Q. And on the right-hand side it says, if I'm reading your handwriting right, it says "was friendly (too)" and that is a symbol for "[with] PSWs"?

A. Yes.

Q. Do you recall what the issue

12:45:04 1 was, was too friendly with PSWs at the time?
12:45:12 2 A. I can't really recall, but I
12:45:15 3 think she was spending too much time talking
12:45:17 4 and visiting and not really performing.
12:45:18 5 Q. Okay. And then under
12:45:22 6 "Accountability," she is rated at 2.5 on
12:45:26 7 "Assumes and accepts responsibility of
12:45:29 8 position" and "Knowledge of adherence to policy
12:45:31 9 and procedures." So still needs development
12:45:34 10 there?
12:45:35 11 A. Yes.
12:45:36 12 Q. And then down at the bottom
12:45:43 13 "Promotes a positive team approach," how was
12:45:46 14 she rated there?
12:45:47 15 A. She was rated a 4.
12:45:54 16 Q. And then over on page 2,
12:46:00 17 scroll down the page "Interaction With others,"
12:46:04 18 it says "Interacts well with Residents and
12:46:07 19 their families," and you have rated her a 2.5,
12:46:11 20 she has rated herself, it appears, a 4; is that
12:46:13 21 correct?
12:46:13 22 A. Yes.
12:46:13 23 Q. And it says "Learn to walk
12:46:18 24 away from residents."
12:46:22 25 Do you know at this point in
12:46:23 26 time, and I know it is a long time ago, was
12:46:26 27 there an issue with her with any residents?
12:46:29 28 A. I'm sure there was, but I
12:46:31 29 can't really recall which one.
12:46:33 30 Q. And in general over the
12:46:35 31 years, did you have an opportunity to see her
12:46:37 32 with residents?

12:46:39 A. Yes.
12:46:40 Q. And can you describe how she
12:46:41 was with the residents while she was at
12:46:43 Caressant Care?
12:46:44 A. Usually when I saw her, she
12:46:52 was interactive with residents, friendly, but
12:46:56 she did have, you know, a couple of issues, and
12:46:59 I don't know if it was before or after this
12:47:01 time, with a couple of residents.
12:47:04 Q. Thank you. Anything in terms
12:47:09 of her interactions with the residents that
12:47:11 would have caused you alarm over the years?
12:47:14 A. Not so much alarm as -- you
12:47:25 know, the one in particular, it was in the
12:47:27 morning, that I recall and, you know, it was
12:47:33 after working a night shift and I thought she
12:47:37 was, you know, tired and not so under control.
12:47:46 Q. Sorry, is that something that
12:47:47 is referred to in your affidavit?
12:47:49 A. Yes.
12:47:49 Q. Okay, we'll get to that, so
12:47:51 you don't have to.
12:47:52 So we'll just finish this off,
12:47:53 and then it would probably be an appropriate
12:47:55 time for the break. Under "Areas of
12:47:59 proficiency," you say "Team conference summary
12:48:02 is well done", and "teaching small e's" -- does
12:48:04 that say "teaching small 'e's and summer
12:48:08 students"?
12:48:09 A. These were students, our high
12:48:11 school students that would come in after
12:48:14 school, and the summer students would be

12:48:22 1 students that were in college or university for
12:48:25 2 the RPN program or the Registered Nurse program
12:48:28 3 that would help us out in the summer.
12:48:30 4 Q. And what have you got for
12:48:32 5 "Areas For Development" for her as of this
12:48:37 6 period of time in her career?
12:48:38 7 A. "Learn policy and procedures
12:48:39 8 of the home," and she is telling me that she
12:48:42 9 plans to take an assessment course.
12:48:44 10 Q. And then finally over at the
12:48:49 11 last page, it has, I believe, your appraisal at
12:48:55 12 this point in time and her appraisal?
12:48:57 13 A. Yes.
12:48:57 14 Q. What is your summary at this
12:49:00 15 point in time?
12:49:02 16 A. "Bethe, you are an asset to
12:49:05 17 Caressant Care and have grown
12:49:07 18 professionally in geriatric
12:49:09 19 knowledge."
12:49:10 20 Q. And did you believe that to
12:49:11 21 be true at the time?
12:49:12 22 A. Yes, I did.
12:49:12 23 Q. And her comment:
12:49:14 24 "I enjoy working at Caressant
12:49:15 25 Care. I agree to do my best to
12:49:17 26 meet my goals this coming year."
12:49:19 27 A. Correct.
12:49:21 28 Q. Now, how often would you do
12:49:24 29 performance reviews?
12:49:25 30 A. I didn't do them every year,
12:49:26 31 but I'm quite sure that I did more than two in
12:49:28 32 her time there.

12:49:29 Q. And what you are referring to
12:49:30 is the next -- what we'll see as the next
12:49:36 Performance Appraisal in her file was not until
12:49:39 2013; is that correct?
12:49:40 A. That's correct.
12:49:41 Q. And your recollection would
12:49:44 be there were more but they simply cannot be
12:49:46 located?
12:49:46 A. Yes.
12:49:47 Q. All right. I think that is
12:49:49 an appropriate time for a break, Commissioner?
12:49:51 THE COMMISSIONER: All right,
12:49:52 thank you.
12:49:52 And so just to make sure that I
12:49:54 am clear, today we are going to
12:49:57 stay with our one-hour for the
12:50:00 lunch recess; is that correct?
12:50:01 MS. HEWITT: That's correct.
12:50:02 THE COMMISSIONER: Thank you.
12:50:02 -- RECESSED AT 12:51 P.M.
13:53:28 -- RESUMED AT 1:52 P.M.
13:53:28 THE COMMISSIONER: Just before
13:53:32 you get going, Ms. Hewitt, they
13:53:34 want to clean the courtroom over
13:53:35 the weekend. I don't know if
13:53:36 people were thinking that they
13:53:38 were going to leave anything in
13:53:38 the room. Is there a problem if
13:53:40 we clean everything out? I
13:53:42 don't think -- so because at
13:53:43 nights we are keeping it all
13:53:45 locked and not letting in

cleaning staff or anything else, but they should clean once a week.

So unless that is a problem, I'm just going to say go ahead, and everybody will have, including me, have all our documents out of here.

MS. HEWITT: Thank you, Commissioner.

THE COMMISSIONER: Go ahead, when you are ready.

BY MS. HEWITT:

Q. Thank you very much, Commissioner.

Good afternoon again, Helen.

I just want to clean up a few things there, and thank you to Mr. Sandler for bringing this to my attention. There is just a couple of other documents in 2007 and 2008 that I wanted to review, and it is all leading up to your December 2008 Performance Appraisal, but just for the completeness of everything, I'll take you to them.

The first is actually -- it is not in your affidavit. It is document 16918. It is in the Overview Report at Exhibit 6, Volume 5, Commissioner.

And, Amanda, the next one I'll be going to is 16917.

So you have to read this on your screen, Helen.

13:55:10 A. Okay.
13:55:12 Q. And this purports to be an
13:55:38 email from Marie Buckrell to yourself, and just
13:55:49 take your time and just read through that for a
13:55:52 moment with me, or yourself.
13:55:55 A. (Witness reviews document.)
13:55:55 MS. STRATTON: Is that too big?
13:56:02 BY MS. HEWITT:
13:56:02 Q. That is too big. That is too
13:56:04 small.
13:56:04 Just let me know when you have
13:56:11 had an opportunity, Helen.
13:56:14 A. (Witness reviews document.)
13:56:50 Q. And my question, first of
13:56:51 all, is if you have any independent
13:56:54 recollection of this issue?
13:56:55 A. No, I don't.
13:56:56 Q. And do you know what it is
13:56:57 referring to, what type of incident is referred
13:56:59 to on this email?
13:57:15 MS. HEWITT: Commissioner, it
13:57:17 looks like we might have some
13:57:18 technological difficulties.
13:57:20 COURT SERVICES OFFICER: We are
13:57:23 getting some feedback, and I am
13:57:25 not sure from where. If we
13:57:36 could get some IT assistance,
13:57:40 Your Honour.
13:57:43 BY MS. HEWITT:
13:57:43 Q. Is that going to be
13:57:44 distracting to you, Helen?
13:57:46 A. Well, it is, you know, hard

13:57:47 to hear, so I think we'll need to speak louder.
13:57:57 I believe Bethe went home and
13:58:00 had signed for medications that she didn't
13:58:02 give.
13:58:03 Q. Would that be a medication
13:58:05 error?
13:58:05 A. Yes.
13:58:06 Q. And the other issue talks
13:58:08 about 3:00 to 11:00 staff who were sitting --
13:58:23 magic.
13:58:24 THE COMMISSIONER: Turn it down.
13:58:26 THE WITNESS: He just put his
13:58:28 hand in front of it.
13:58:30 BY MS. HEWITT:
13:58:31 Q. The other item on the bottom
13:58:34 is:
13:58:34 "3 to 11 staff who were sitting
13:58:37 in the dining room at 2215 while
13:58:40 three bells were ringing - Sue
13:58:42 had asked them to answer bells
13:58:43 more than once before 2300. She
13:58:45 asked them about rounds and was
13:58:47 told they where starting soon.
13:58:51 While she was giving meds, she
13:58:52 noted they did go in and out of
13:58:54 some rooms, but feels rounds
13:58:56 were not done well."
13:58:59 So do you recall any of this
13:59:00 being brought to your attention at the time?
13:59:02 A. I don't recall it, no.
13:59:04 Q. All right. If we can go to
13:59:06 document 16917 and this indicates it is an

13:59:24 investigative meeting with Bethe Wettlaufer and
13:59:28 in attendance there are Bethe Wettlaufer,
13:59:33 Mirian Wright. So what would Mirian's role be
13:59:42 there?
13:59:42 A. It looks like she was either
13:59:42 the union rep.
13:59:42 Q. All right. And if we just go
13:59:42 down to the second paragraph, it indicates:
13:59:46 "Beth did not deny that she
13:59:47 indeed did not give out [the
13:59:51 Resident] medication, and
13:59:51 realized immediately that she
13:59:53 had made an error. Beth also
13:59:55 signed for another room that had
13:59:56 not received their pills. Beth
13:59:57 said that she signs for the
13:59:59 pills, pours them and then goes
14:00:00 into the room with the
14:00:03 medication. She was apparently
14:00:05 doing this just this when Sue
14:00:08 Kungl came in, and Beth did not
14:00:11 finish what she was doing. When
14:00:12 asked how she could avoid this
14:00:14 in the future, Beth said that
14:00:15 she would leave a note to
14:00:16 herself on top of the medication
14:00:17 cart. Mrs. Crombez told Beth
14:00:19 that she must change her
14:00:20 procedure to signing after
14:00:21 giving the medication.
14:00:23 Mrs. Crombez also brought up
14:00:25 with Beth her attendance.

14:00:27 1 Mrs. Crombez told Beth that her
14:00:29 2 attendance is below that which
14:00:30 3 is expected of a professional,
14:00:33 4 and that perhaps she make some
14:00:35 5 lifestyle changes or talk to her
14:00:37 6 Doctor. Beth agreed with this."
14:00:40 7 And then it indicates:
14:00:41 8 "A note was left in the
14:00:43 9 communication book to Reg Staff
14:00:46 10 reviewing the proper procedure
14:00:49 11 for medication administration."
14:00:53 12 Does that assist you any in
14:00:54 13 recalling the actual incident?
14:00:56 14 A. It doesn't, but I believe
14:00:58 15 that it happened and this is a true summary of
14:01:02 16 that conversation.
14:01:03 17 Q. And having read that
14:01:05 18 paragraph in terms of Ms. Wettlaufer's
14:01:07 19 explanation, what is your view of the type of
14:01:11 20 incident that was taking place at this
14:01:13 21 particular time?
14:01:14 22 A. This was a medication error.
14:01:16 23 Q. All right. And this
14:01:19 24 identifies the actions that you took?
14:01:21 25 A. Yes.
14:01:21 26 Q. Now, was there any particular
14:01:24 27 discipline in terms of a verbal warning or a
14:01:27 28 suspension?
14:01:28 29 A. There was no warning as far
14:01:34 30 as I can tell, because it is not noted in this
14:01:37 31 conversation.
14:01:37 32 Q. All right. And even though

there was no discipline given, there was still union representation for Ms. Wettlaufer in that meeting?

A. That's correct.

Q. Thank you. Now, if we go back to your exhibit at Exhibit No. II and that is document number 16907 and this is a Medication Incident Report. We have seen a couple of these reports before.

Now, you indicated in your affidavit that you didn't have any independent recollection of this particular issue, but just for the record, we'll identify it, in any event.

It is an incident that purports to, if I'm reading this right, have occurred on June 22nd at 2000 hours; is that correct?

A. That's correct.

Q. And the brief description of the incident is:

"20.00 hydromorph Contin 3 mg. not given by BW [...]"

Which would you understand that to be Bethe Wettlaufer?

A. That's correct.

"[...] RN, still in card at 0800 med pass on Monday."

Is that correct?

A. Yes.

Q. Now, you say that you had no independent recollection of this. The writing on the top left-hand side, whose handwriting is

14:03:37 1 that?
14:03:37 2 A. That I believe was Marie's,
14:03:40 3 Marie Buckrell.
14:03:40 4 Q. And she was your Assistant
14:03:42 5 Director of Nursing?
14:03:42 6 A. Well, either the assistant or
14:03:48 7 at one point she was made Director of Nursing.
14:03:53 8 Like, the building was split in half, so I'm
14:03:55 9 not sure what her title was at this point.
14:03:57 10 Q. All right. And so this
14:03:59 11 document was found within Elizabeth
14:04:04 12 Wettlaufer's employment file. Would Marie have
14:04:06 13 spoken to you about these types of issues if
14:04:08 14 they were arising?
14:04:09 15 A. I believe she would have.
14:04:11 16 Q. Okay. And are you aware as
14:04:19 17 to whether any discipline was given in respect
14:04:21 18 of that particular situation?
14:04:22 19 A. I don't recall.
14:04:28 20 Q. All right, thank you. I'm
14:04:29 21 going to take us away right now from the
14:04:32 22 medication incidents. I'll revisit that later
14:04:34 23 when we talk about what happened towards the
14:04:37 24 end of Bethe Wettlaufer's career, but now I
14:04:39 25 want to take you to the issue of investigating
14:04:40 26 issues and incidents that arise.
14:04:44 27 First of all, do you have any
14:04:47 28 formal training on how to investigate
14:04:49 29 incidents, and what I mean by that in terms of
14:04:51 30 how to gather evidence, how to conduct
14:04:53 31 interviews, how to document what you are doing,
14:04:55 32 that type of thing?

14:04:56 A. No, not any formal training.
14:05:00 Q. All right. So how did you
14:05:02 learn how to perform the investigations that
14:05:06 you were doing during your career as Director
14:05:09 of Nursing?
14:05:09 A. Well, usually by mistake, I
14:05:18 think. We would investigate and perhaps give a
14:05:21 grievance or give a discipline, and then it
14:05:26 would be grieved and it wouldn't go anywhere or
14:05:32 be, you know, dropped back or rescinded. And
14:05:38 so it was kind of learn as you go.
14:05:40 Q. Now, we have heard about one
14:05:44 union that you were dealing with at Caressant
14:05:46 Care and that is ONA. Were there any other
14:05:49 unionized employees at Caressant Care?
14:05:52 A. Yes, there was, when I first
14:05:53 started it was CLAC, and then it became CAW,
14:05:57 and then it became Unifor.
14:06:00 Q. So CLAC is the acronym
14:06:04 C-L-A-C?
14:06:05 A. Yes, Christian Labour
14:06:07 Association something of Canada.
14:06:10 Q. And who was that organization
14:06:12 the union for?
14:06:13 A. For the PSWs and the RPNs.
14:06:22 Q. And at some point in time did
14:06:22 ONA take over the RPNs?
14:06:24 A. No.
14:06:24 Q. No? So it just remained
14:06:28 CLAC?
14:06:28 A. Yeah.
14:06:29 Q. All right. And was that the

14:06:34 same at the end of the day when you left
14:06:35 Caressant Care?
14:06:35 A. I believe so, yes.
14:06:36 Q. So when you are talking to us
14:06:38 about you would get a discipline and it would
14:06:40 be grieved, are you talking about solely issues
14:06:43 with ONA or was it those issues as well with
14:06:47 the other union?
14:06:47 A. They were more with the other
14:06:49 union.
14:06:50 Q. So that is where you learned
14:06:52 in terms of grievances and documentation, okay.
14:07:00 Now, I just want to take you
14:07:04 briefly through the absenteeism issue that is
14:07:08 found at -- it starts at paragraph 90 of your
14:07:15 affidavit. And if I can turn us first -- that
14:07:20 is Exhibit No. 8, Commissioner.
14:07:21 And I'm going to start with the
14:07:30 first one that had a verbal warning, which is
14:07:33 July 7th, 2010. I don't want to take you to
14:07:37 the letter. It was a verbal warning. It is
14:07:40 already in evidence, and Ms. Van Quaethem
14:07:43 reviewed it.
14:07:44 But I do want take you to
14:07:46 document 16884, which is the second -- I
14:07:58 believe it is the fourth document in. It is a
14:07:59 set of handwritten notes, Commissioner.
14:08:02 THE COMMISSIONER: Yes, thank
14:08:02 you.
14:08:03 BY MS. HEWITT:
14:08:05 Q. Do you recognize this
14:08:06 handwriting?

14:08:08 A. This is Marie Buckrell's writing.
14:08:10 Q. All right. And is this a meeting at which you were present?
14:08:11 A. Yes, I believe I was talking.
14:08:14 Q. And who else --
14:08:20 A. And Marie was documenting, sorry.
14:08:21 Q. So it would be yourself, Marie Buckrell, it says Karen R., and who would Karen R. be?
14:08:23 A. Karen Routledge and she was the ONA rep, I believe.
14:08:25 Q. And it indicates a third of the way down the page:
14:08:29 "Helen. Yesterday you called in at 2 p.m. for 3 p.m. shift. We feel you are full time and expect you to be here."
14:08:31 So in terms of this, was it an incident where she had called in shortly before her shift was due?
14:08:32 A. Yes, this was -- I don't remember the date on the top of the form, but it was July 6th she called in at 2:00 p.m. and she was expected to be there at 3:00, which was not acceptable.
14:08:34 Q. And when what happens, what effect does that have in the home, if you have got an RN calling in just before shift?
14:08:41 A. Well, there aren't a lot of options, you know, that late in the day, so we
14:08:43
14:08:45
14:08:48
14:08:49
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14:09:28
14:09:32

14:09:36 would probably have asked one of the other RNs
14:09:38 in the building if they could stay, you know,
14:09:41 until we found coverage. And if we weren't
14:09:46 successful, then we would ask the night RN to
14:09:49 come in early to try and cover that.
14:09:50 Q. All right. And it goes on to
14:09:53 say:
14:09:54 "Bethe stated 'I only call in
14:09:57 sick when I am sick and the
14:09:59 personal days can't be helped.'"
14:10:02 So that is Ms. Wettlaufer
14:10:04 speaking?
14:10:04 A. Yes.
14:10:04 Q. And then:
14:10:06 "We are giving you a verbal
14:10:07 warning for the above. We did
14:10:08 discuss the expectations when
14:10:09 you took this full time line.
14:10:11 Bethe wanted to know if she was
14:10:12 not allowed to have a sick day?"
14:10:15 So that is the outcome of that
14:10:16 particular meeting?
14:10:17 A. Yes.
14:10:17 Q. All right. And if I can
14:10:22 quickly take you then to document 16870. This
14:10:43 is again a Disciplinary Action Form dated March
14:10:46 31st, 2011?
14:10:48 A. Yes.
14:10:48 Q. And does it identify the type
14:10:50 of discipline that Elizabeth Wettlaufer was
14:10:54 being given?
14:10:55 A. She received a:

14:10:57 "Written warning with notice
14:10:59 that continuing absenteeism will
14:11:02 result in disciplinary action up
14:11:03 to and including termination."
14:11:08 Q. And Ms. Routledge signs as
14:11:09 the union rep?
14:11:11 A. Yes.
14:11:11 Q. And under "Additional
14:11:12 information" it identifies:
14:11:15 "Management requires you to
14:11:16 bring in a Doctor's note from
14:11:18 now on dated the day of your
14:11:19 illness."
14:11:20 What does that refer to?
14:11:22 A. Well, we were asking her to
14:11:24 bring in a doctor's note when she was ill the
14:11:30 day of her illness to try and make her more
14:11:36 accountable.
14:11:37 Q. Thank you. And then document
14:11:41 16867, and is this a second written warning
14:12:01 that you are providing Elizabeth Wettlaufer?
14:12:04 A. That's correct.
14:12:04 Q. And you note on the bottom
14:12:08 right-hand side:
14:12:10 "First Written Warning March 31,
14:12:14 2011. Must bring a doctor's
14:12:16 note for illness [...]"
14:12:18 Is that correct?
14:12:18 A. That's correct.
14:12:19 Q. And you are referring to the
14:12:20 previous document?
14:12:21 A. That's correct.

14:12:22 Q. And it identifies under
14:12:23 "Union rep," is that scratched out and
14:12:26 "Witness"?
14:12:27 A. That's correct.
14:12:27 Q. And do you know who that was?
14:12:29 A. That was Jennifer Hague.
14:12:31 Q. All right. If I can take you
14:12:37 to document 16858. And this is dated August
14:12:54 26, 2011?
14:12:57 A. Yes.
14:12:57 Q. And what is the discipline on
14:12:58 this particular occasion?
14:13:02 A. This is a:
14:13:03 "1 day suspension on paper with
14:13:05 notice that continuing
14:13:05 absenteeism will result in
14:13:07 disciplinary action up to and
14:13:09 including termination."
14:13:11 Q. And did Ms. Wettlaufer have
14:13:13 union representation?
14:13:14 A. She did. She had Karen
14:13:16 Routledge.
14:13:16 Q. And then finally, January
14:13:22 18th, 2011, document 16818. Do you see that?
14:13:45 A. Yes, I do.
14:13:46 Q. Now, this document is signed
14:13:50 by Ms. Van Quaethem. Would you have seen this
14:13:53 document at the time that she would have been
14:13:54 delivering it to Ms. Wettlaufer?
14:13:56 A. I believe I was probably a
14:14:00 witness to this, this happening. We started an
14:14:05 attendance management program, I believe, and

14:14:10 Brenda averaged out the absenteeism days per
14:14:17 the previous year for all staff, and I believe
14:14:20 it was six or so.
14:14:24 Q. The average, you mean?
14:14:26 A. The average, yes, and, you
14:14:30 know, she was way above that, and so we gave
14:14:37 her a letter.
14:14:38 Q. All right, thank you. And at
14:14:39 the bottom it says it is copied to the union.
14:14:42 Do you have any reason to believe that the
14:14:45 union didn't receive a copy of this letter?
14:14:47 A. No, I have no reason not to
14:14:51 believe this.
14:14:52 Q. All right. So if we can then
14:14:55 turn to the issues of disputes that Ms.
14:15:01 Wettlaufer may have had with her co-workers,
14:15:05 can you tell me generally how she got along
14:15:08 with her co-workers and what was your
14:15:10 impression of the type of disputes that were
14:15:13 arising with her?
14:15:14 A. Well, she got along with, you
14:15:25 know, some of the staff very well, but there
14:15:30 were certainly complaints about her behaviour
14:15:35 with other staff.
14:15:35 Q. All right, and did you deal
14:15:37 with her from time to time on those issues?
14:15:40 A. Yes.
14:15:40 Q. In paragraph 92 of your
14:15:44 affidavit, and I will just read it, Amanda, you
14:15:48 don't need to go there said:
14:15:50 "One of the big issues with
14:15:52 Elizabeth Wettlaufer was more

her comments about her sexual orientation and being too friendly with the students, inviting them to have pizza with her or inviting them to her home and the way she talked about her partners."

Was that one of the issues that you would have been dealing with with Elizabeth Wettlaufer.

A. That's correct.

Q. If I can turn you to document number 16898. You have had an opportunity to review this document, Helen?

A. I have.

Q. All right, and in respect of this document, and I won't take you to all of the documents, but there are a number of documents indicating an investigatory meeting with yourself -- sorry, with Marie Buckrell, Bethe Wettlaufer, Brenda and Karen Routledge, but in general when you reviewed this, what was your view of the situation that was occurring at the time?

A. Well, I believe the complainant was Libby, and I thought that she was a very nice person and a good nurse, so I was upset that, you know, there was trouble amongst the registered staff. They are supposed to be professional and be a cut above, if you will, and this was, you know, poor behaviour.

14:17:49 Q. All right. Now, we'll leave
14:17:51 that because we did canvass that in detail
14:17:53 yesterday with Ms. Van Quaethem.
14:17:55 If I can take you to the
14:18:01 incident on January 19th, and this is document
14:18:08 16888 found, sorry, Commissioner, at tab K,
14:18:16 Exhibit K. And I won't read this back into the
14:18:31 record, because I read it yesterday, Helen, but
14:18:32 it identifies that there was an issue on shift
14:18:34 between Bethe Wettlaufer and another RN when
14:18:39 the other RN was using the residents' last
14:18:42 names. Do you recall this incident?
14:18:45 A. Yes, I do.
14:18:46 Q. And what was your view as the
14:18:48 Director of Nursing as to what was taking place
14:18:50 here between Elizabeth Wettlaufer and this
14:18:53 other nurse?
14:18:55 A. Well, I did feel that Bethe
14:19:00 had a point, you know. I respected the
14:19:03 residents and I like people to call them by
14:19:05 their full name or use "Mr." and "Mrs." so in
14:19:10 that respect I thought Bethe was echoing, you
14:19:13 know, what I felt myself.
14:19:15 Q. And then this particular
14:19:19 situation goes on to say that there was -- Ms.
14:19:25 Wettlaufer showed this particular nurse her
14:19:27 boil, and what the nurse says is:
14:19:30 "Before I could respond, she
14:19:31 pulled down the right side of
14:19:33 her uniform bottom so she would
14:19:35 show it to me. I am sure she is
14:19:36 not aware that she was exposing

14:19:38 part of her groin."
14:19:42 What about that particular
14:19:43 situation in terms of Ms. Wettlaufer?
14:19:45 A. Well, it wasn't appropriate,
14:19:53 and I also thought, you know, going back to the
14:19:55 first part of the complaint, that Bethe could
14:20:01 have handled it better than, you know, being
14:20:04 kind of abrupt about it or rude about it.
14:20:10 Q. And the documentation, you
14:20:17 don't have to pull it up, Amanda, because we
14:20:19 did go through it yesterday, at 16890 indicates
14:20:25 that you had a meeting with Elizabeth
14:20:26 Wettlaufer and Karen Routledge and Brenda?
14:20:36 A. Yes.
14:20:36 Q. And what was the outcome of
14:20:37 this particular issue?
14:20:38 A. Can you refer me to the
14:20:39 document? Do we have it?
14:20:40 Q. Yes, we can go to the
14:20:42 document or -- it is 16890. I think your
14:20:46 affidavit identifies that this particular
14:20:50 incident resulted in counselling.
14:21:11 A. Is it in my document?
14:21:12 Q. Yes, it is at tab K, the last
14:21:16 document at tab K.
14:21:18 A. Tab, sorry, which?
14:21:20 Q. Tab K.
14:21:20 A. K?
14:21:26 THE COURT CLERK: It is 16890.
14:21:30 THE WITNESS: Yes. This was
14:21:43 just a counselling, I think.
14:21:47 BY MS. HEWITT:

14:21:47 Q. All right, thank you. Now, there is a document within the file that identifies that at one point there was a complaint and Brenda Van Quaethem, and this is in June of 2011, emailed Cheryl MacDonald at head office to discuss some comments that Elizabeth Wettlaufer had made in a meeting about her feeling targeted about feeling gay; do you remember that?

A. Yes, uhm-hmm.

Q. So if I can turn you to that particular two documents, 16862, and, Commissioner, that is at tab number L. And that is a meeting that you are holding, Helen, with Bethe Wettlaufer, and it identifies Karen Rodrigues, who was that?

A. That is an error. She was another -- she was the union rep for the other union. This should be Karen Routledge.

Q. All right. So your belief is that Karen Routledge would have been at this meeting?

A. That's correct.

Q. Okay. And then in terms of this particular situation, whose handwriting is this again?

A. This is my handwriting.

Q. And it indicates:

"Had a complaint that you made a comment about how she looked and the comment was not an appropriate one for the

14:23:34 workplace."
14:23:36 A. That's correct.
14:23:36 Q. And then down two lines:
14:23:38 "It could be the fact that I am
14:23:40 a lesbian."
14:23:42 Do you recall her using that
14:23:44 particular situation to explain what was
14:23:46 happening or why there were complaints being
14:23:49 given?
14:23:49 A. Yes, I do.
14:23:50 Q. And was that on this one
14:23:53 occasion? Was that on more than one occasion?
14:23:58 Or do you recall?
14:23:59 A. I know it happened this time.
14:24:04 I don't know -- I can't recall that it happened
14:24:06 another time.
14:24:06 Q. All right.
14:24:08 A. Off the top of my head.
14:24:10 Q. And your affidavit indicates
14:24:12 that she was given counselling for this
14:24:14 particular situation; is that correct?
14:24:16 A. That's correct.
14:24:17 Q. Okay. I do want to take some
14:24:26 time to go through a document we only briefly
14:24:30 touched on with Ms. Van Quaethem the other day,
14:24:34 and that is document 16841 and it is an email
14:24:38 that is addressed to you and copied to Brenda
14:24:42 Van Quaethem.
14:24:43 Do you recall this particular
14:24:54 email, Helen?
14:24:55 A. Yes, I do.
14:24:59 Q. And --

14:25:01 A. Well, I don't recall it, but
14:25:03 I know it happened, yes.
14:25:04 Q. And I read it all into -- I
14:25:07 believe I read it into the record yesterday, so
14:25:11 I won't do that again. But the first paragraph
14:25:13 of that is talking about the narcotic counts
14:25:16 and when they are done and who is doing it; is
14:25:19 that correct?
14:25:19 A. Yes.
14:25:20 Q. So can you explain to us,
14:25:22 first of all, in respect of that issue, this
14:25:28 particular employee at the very end of that
14:25:30 first paragraph says:
14:25:34 "[...] I was in the lounge and
14:25:35 you should have called my name.
14:25:36 Now I thought it was the time to
14:25:38 speak up and made it very clear
14:25:39 to her that I will not be coming
14:25:42 for count anymore and it is not
14:25:43 my job. Moreover, I was not
14:25:46 sure if the ministry and
14:25:48 management will accept this
14:25:49 arrangement."
14:25:52 Do you know what he is talking
14:25:53 about in that particular paragraph?
14:25:56 A. Well, I think it is, you
14:25:57 know, a bit of an understatement, because, you
14:26:02 know, when we organized the narcotic count, it
14:26:04 was supposed to be at change of shift. So
14:26:10 doing it at 4:30, there are still medications
14:26:14 that the night nurse gives at 6:00, and if
14:26:19 someone asks for a narcotic medication, how can

14:26:25 you count accurately if that is to happen yet?
14:26:29 Q. And is this particular
14:26:32 employee an RN or an RPN?
14:26:34 A. I believe he was trained as
14:26:40 an RN in India but he was working for us as an
14:26:44 RPN.
14:26:45 Q. And so if we look at the time
14:26:47 that this is taking place, and that is 0430,
14:26:50 and that would be the night shift; correct?
14:26:52 A. That's correct.
14:26:53 Q. And so if I recall our
14:26:55 discussion earlier this morning about shifts,
14:26:58 on the night shift at Caressant Care would be
14:27:01 one Registered Nurse and one Registered
14:27:05 Practical Nurse?
14:27:05 A. That's correct.
14:27:05 Q. And Bethe Wettlaufer would be
14:27:08 the nurse in charge; is that correct?
14:27:10 A. That's correct.
14:27:11 Q. And in this particular
14:27:14 situation, he is working in the other part --
14:27:19 she is in Section B and he is working in the
14:27:21 other part?
14:27:21 A. That's correct.
14:27:22 Q. And he is identifying he is
14:27:24 having to come over and do narcotic count?
14:27:26 A. Yes.
14:27:27 Q. And so I thought that the
14:27:28 process was that the on-coming shift does
14:27:31 narcotic count?
14:27:32 A. Yes.
14:27:32 Q. So was this -- the way that

14:27:36 this was taking place, not to mention the
14:27:39 timing, but the way they were doing it, was it
14:27:43 accurate?
14:27:44 A. It was a shock to me.
14:27:46 Q. All right. So do you recall
14:27:48 whether it did shock you? It was emailed to
14:27:52 you.
14:27:52 A. Yes, I dealt with it,
14:27:53 actually. I reviewed the process with all the
14:27:58 staff. I don't know if I typed out a memo or
14:28:04 wrote it in the communication books in each --
14:28:10 sometimes I would type it out and then copy it
14:28:13 three times and take it to each communication
14:28:15 book, and I talked, you know, to the staff
14:28:18 one-to-one when I saw them and I said, you
14:28:20 know, this has to change.
14:28:23 Q. Was it more than Bethe
14:28:25 Wettlaufer that was doing it this way?
14:28:26 A. I don't believe so, but it
14:28:30 wasn't right and it, you know, had to change
14:28:32 immediately.
14:28:34 Q. Was there any explanation
14:28:36 given as to why this particular practice had
14:28:38 developed in the home at night?
14:28:39 A. I can't recall.
14:28:43 Q. All right. And so that is
14:28:45 how you dealt with this situation from the
14:28:48 employee?
14:28:49 A. Yes.
14:28:50 Q. Now, on the bottom it says:
14:28:52 "Manju emailed and did not want
14:28:56 action taken."

14:28:58 That is not your handwriting, is
14:29:00 it?
14:29:00 A. No, that is Brenda's
14:29:01 handwriting.
14:29:01 Q. And do you understand what
14:29:03 was meant by that?
14:29:04 A. Well, I believe Manju didn't
14:29:07 want Bethe to know that he had complained about
14:29:10 her, so that is how I handled the situation.
14:29:18 Q. All right, thank you. Now,
14:29:23 in terms of Ms. Wettlaufer's work performance,
14:29:30 how did you generally find her as a nurse?
14:29:33 A. Well, she -- whenever I saw
14:29:41 her in the hallway, she seemed to be
14:29:45 interacting well, you know, with the residents.
14:29:52 She was, you know, pleasant and polite. She
14:29:57 would ask how my day was going. You know, she
14:30:02 would talk to me about particular residents.
14:30:05 If I had had a concern about someone, she would
14:30:11 say oh, you know, I think there -- or she told
14:30:17 me so-and-so seems to be over the hump; she has
14:30:24 been on, you know, the antibiotic for three
14:30:28 days, four days, and I fed her supper, and, you
14:30:31 know, she ate pretty well.
14:30:35 Q. Well, let's go through some
14:30:37 of the issues that may have developed over the
14:30:39 years, and I will turn you to document 16886.
14:31:01 And that is a letter dated February 27th, 2009,
14:31:05 and, as I understand it, this pre-dates Ms. Van
14:31:09 Quaethem's coming to Caressant Care; is that
14:31:11 correct?
14:31:11 A. That's correct.

14:31:11 Q. And you signed this letter as
14:31:14 Director of Nursing?
14:31:15 A. Yes.
14:31:19 Q. And it indicates:
14:31:20 "Items discussed were eating at
14:31:23 the desk, taking and eating
14:31:24 nursing home food, leaving the
14:31:26 building on your break and not
14:31:27 following through with your
14:31:28 nursing duties."
14:31:30 Now, the only thing that so far
14:31:33 we were able to locate is this letter.
14:31:35 A. Uhm-hmm.
14:31:35 Q. Do you recall this situation
14:31:38 at all?
14:31:39 A. No, I don't recall.
14:31:43 Q. Okay. Did you have a concern
14:31:48 about her leaving the building on her break?
14:31:51 A. I certainly did.
14:31:52 Q. What would that concern be?
14:31:54 A. Well, if -- you know, she was
14:31:59 the Charge Nurse. What if, you know, a fire
14:32:02 had started, and, you know, she was supposed to
14:32:04 lead, you know, the fire plan, the evacuation,
14:32:11 you know, calling the fire department, that
14:32:13 kind of thing.
14:32:13 Q. Okay. And taking and eating
14:32:17 nursing home food, does that mean she is taking
14:32:19 and eating food that the residents would
14:32:21 normally eat?
14:32:23 A. That's correct.
14:32:23 Q. Do you know -- so you have no

14:32:25 recollection as to how these issues were
14:32:27 brought to your attention?
14:32:28 A. No.
14:32:29 Q. And no recollection of "not
14:32:31 following through on your nursing duties," what
14:32:37 that means?
14:32:38 A. No.
14:32:38 Q. All right, that is fine.
14:32:45 Sorry, Commissioner, I'm going too fast, and I
14:32:48 didn't give you that number. It is number "O."
14:32:51 THE COMMISSIONER: Thank you.
14:32:51 BY MS. HEWITT:
14:32:53 Q. So if I can turn to tab P,
14:32:57 which is document number 16877. Can you
14:33:20 identify the handwriting on this particular
14:33:22 note?
14:33:22 A. Yes, that was Marie Buckrell.
14:33:25 Q. And present is yourself,
14:33:29 Karen Routledge and Elizabeth Wettlaufer and
14:33:33 Marie Buckrell?
14:33:34 A. That's correct.
14:33:36 Q. Now, we asked Brenda
14:33:40 yesterday about this, but she thought -- she
14:33:43 deferred, I believe, to you because it is
14:33:49 nursing issues. So it indicates on this letter
14:33:50 that there were no treatments done on Level 2?
14:33:56 A. Yes.
14:33:57 Q. And there is an issue at the
14:34:00 bottom of the page:
14:34:01 "Your RIA/MDS assignments, you
14:34:05 scored 0 out of 105."
14:34:09 So can you just expand with us

what the issues were that you were dealing with in February 2011?

A. She -- well, somehow we knew that she didn't do treatments, whether, you know, some residents complained or she didn't sign for them, or she didn't sign, that is what it says. And I think a resident complained that she didn't have a treatment, and I told her that treatments were just as important as medications.

And then she says that she just gave out the prescription creams, and I told her we were giving her a verbal warning.

Q. And what did she say?

A. "That is fair."

Q. Now, just for our benefit, what type of treatments would be being done by the registered staff?

A. Well, it would be treatments of a skin laceration or -- what else could it be? A skin rash type thing.

Q. And the next part says:

"Your RIA/MDS assignments from December 25 to February 7 you scored 0 out of 105. No bedside assessments. Some PCC assessments."

Is that Point Click Care?

A. Yes, they had different assessments to do under Point Click Care.

Q. Is this the nursing staff?

A. Yes.

14:35:56 Q. And what type of assessments
14:35:59 would they be having to do?
14:36:00 A. Well, I can't, you know --
14:36:04 Q. That is okay. We are
14:36:05 having --
14:36:07 A. Ask the nurses, I think that
14:36:07 would be better.
14:36:08 Q. Okay. So in any event, she
14:36:11 hadn't done those assessments; is that correct?
14:36:13 A. That's correct. She hadn't
14:36:14 done any.
14:36:15 Q. And did she give any excuse
14:36:17 for not having done any?
14:36:19 A. No, not that is documented.
14:36:25 Q. And it says towards the
14:36:29 bottom:
14:36:30 "This will be a verbal. You are
14:36:31 front line staff and are
14:36:32 expected to be part of this for
14:36:34 our funding."
14:36:35 A. That's correct.
14:36:35 Q. And do you know, was that a
14:36:36 reference to the RAI/MDS system?
14:36:39 A. Yes, yes.
14:36:40 Q. Okay. And I won't take you
14:36:41 to them, but there's two Disciplinary Action
14:36:47 Forms at this point in time in February 2011.
14:36:52 They are both dated February 8th and they are
14:36:54 both, for the benefit of counsel, found at
14:37:00 document number 16875.
14:37:05 And on different forms you gave
14:37:07 Ms. Wettlaufer a verbal warning, so on one form

14:37:09 is a verbal warning for not doing the RAI/MDS,
14:37:13 and on another form no treatments done,
14:37:16 including a treatment for a stage 4 ulcer.
14:37:19 Now, why two verbal warnings on
14:37:23 the same day?
14:37:24 A. Well, it was my understanding
14:37:25 that we shouldn't talk about different issues
14:37:36 that occurred on different days, for instance,
14:37:41 at the same meeting. That would be, like,
14:37:44 compiling things. So I didn't want to put it
14:37:47 on one form, but in the interests of time for
14:37:52 the RNs and ourselves, I thought I would put it
14:37:56 on two forms because they were two different,
14:37:59 you know, types of things, and I wanted her
14:38:04 behaviour to change and I wanted it to be
14:38:08 documented.
14:38:09 Q. And so it identifies on your
14:38:13 sheets that you used progressive discipline.
14:38:16 What was your recollection of progressive
14:38:19 discipline and how it worked in the home?
14:38:21 A. My recollection is that it
14:38:25 started off with a counselling. We would
14:38:28 always bring the issue to the staff member
14:38:34 verbally and counselling wasn't considered
14:38:39 discipline.
14:38:41 And then it would progress to a
14:38:43 verbal warning, a written warning, a one-day
14:38:47 suspension, a three-day suspension, a five-day
14:38:50 suspension, and then termination.
14:38:53 Q. And where did you gain that
14:38:56 understanding from?
14:38:57 A. In my dealings with the

14:39:00 union.
14:39:01 Q. Okay. And so on this
14:39:05 particular occasion there's two things that she
14:39:08 has done; one is failure to do the RAI/MDS
14:39:12 audits, and the second one is failure to do
14:39:16 treatments for a stage 4 ulcer.
14:39:18 A. Uhm-hmm.
14:39:18 Q. Why wouldn't you progress and
14:39:21 give her on the same day a verbal and then a
14:39:23 written?
14:39:23 A. I am -- I thought I made a
14:39:29 good decision. I would have discussed it with
14:39:33 Marie and this is what we decided would be
14:39:36 fair.
14:39:36 Q. Okay, thank you.
14:39:40 Now, if we go to tab number Q,
14:39:58 which is document number 16873. Now, it is
14:40:17 dated March 8th, '08 but in the body it
14:40:22 identifies you were working March 3rd, 2011. I
14:40:25 think your affidavit indicates that you just
14:40:27 believe the date '08 is wrong; is that correct?
14:40:30 A. Yes, that's correct.
14:40:31 Q. All right. And this is a
14:40:34 meeting with Bethe Wettlaufer, Helen Crombez,
14:40:39 Karen Routledge as the ONA rep and Ms. Buckrell
14:40:43 again?
14:40:46 A. Yes.
14:40:46 Q. And it indicates in this
14:40:48 document:
14:40:50 "I started and finished the 24
14:40:53 hour assessment, I even stayed
14:40:54 late to do this. Then passed on

14:40:57 1 to 11-7 that this was done."
14:41:01 2 So do you have a recollection of
14:41:02 3 the issues that were being discussed with Ms.
14:41:07 4 Wettlaufer in this particular meeting?
14:41:13 5 A. Not beyond what is documented
14:41:14 6 here.
14:41:14 7 Q. All right. It states -- so
14:41:19 8 let me ask you this, what is the 24-hour
14:41:23 9 assessment?
14:41:23 10 A. The 24-hour assessment or the
14:41:26 11 24-hour trigger were assessments that we
14:41:31 12 completed on admission, and those triggers
14:41:34 13 would feed into the care plan and get it
14:41:37 14 started.
14:41:39 15 And then you would go to the
14:41:41 16 care plan and fine-tune the needs that the
14:41:46 17 resident had, such as eating, toileting,
14:41:51 18 dressing, transferring. It covered the
14:42:00 19 continence levels, so bowel continence and
14:42:05 20 bladder continence, and also behaviours of
14:42:08 21 daily living, if they liked to go bed early, if
14:42:13 22 they liked, you know, that kind of thing.
14:42:15 23 Q. So this is on a resident
14:42:16 24 being admitted into long-term care?
14:42:18 25 A. Yes.
14:42:19 26 Q. And whose responsibility was
14:42:22 27 it to do this assessment?
14:42:23 28 A. It was a team approach.
14:42:25 29 Everyone would do what they could on their
14:42:28 30 shift, and we wanted it completed within 24
14:42:32 31 hours.
14:42:32 32 Q. And when you say "everyone,"

14:42:36 is that just registered staff or just --
14:42:39 A. It was just the registered
14:42:41 staff, yes.
14:42:42 Q. So whoever was on shift would
14:42:44 assist one another with these assessments?
14:42:46 A. Yes.
14:42:47 Q. And Ms. Wettlaufer states --
14:42:54 or sorry, I shouldn't say states. Down the
14:42:56 side of the document where it says:
14:43:02 "Bethe, I stayed until the
14:43:06 2340-2345 and did not put in for
14:43:08 overtime. I did not
14:43:09 specifically tell May to start
14:43:11 the care plan."
14:43:15 Is that Ms. Wettlaufer speaking?
14:43:16 A. Yes, it is.
14:43:17 Q. And then is that you speaking
14:43:19 next?
14:43:20 A. Yes, I reminded her that, you
14:43:22 know, she should be reminding or telling her
14:43:26 co-worker that, you know, I got this and this
14:43:31 done but the care plan still needs work.
14:43:34 Q. Now, is it -- is the issue
14:43:42 that she didn't complete it or she didn't tell
14:43:44 the next shift?
14:43:45 A. I felt that she did make some
14:43:51 attempt to do the work. I noted here that
14:43:58 Agatha had started the 24-hour assessment, and,
14:44:00 you know, that needs to be done before the care
14:44:02 plan is really started.
14:44:06 So if Bethe finished that piece
14:44:11 of the work and stayed later to do it, I

14:44:17 thought that was appropriate.
14:44:20 Q. All right. And if I can turn
14:44:22 you to, in that same tab Q, document 16872, and
14:44:46 this is -- other than some handwriting on it,
14:44:48 it is not signed by anybody; do you see that?
14:44:50 A. That's right.
14:44:54 Q. Now, whose handwriting is on
14:44:58 the top?
14:45:00 A. That is my handwriting.
14:45:01 Q. And what does it state?
14:45:06 A. That we didn't give her
14:45:09 discipline because she did complete the 24-hour
14:45:11 trigger and the head-to-toe assessment, and
14:45:16 that I also noted that she did not give
14:45:18 specific instruction to May to complete the
14:45:22 24-hour care plan, or at least start it.
14:45:25 Q. So is it fair to say that on
14:45:27 this particular occasion there was -- other
14:45:30 than your meeting with her, there was no
14:45:31 discipline?
14:45:32 A. That's correct.
14:45:33 Q. And, sorry, that was wrongly
14:45:35 phrased. The meeting itself wasn't discipline;
14:45:38 it was investigation, is that correct?
14:45:39 A. That's correct.
14:45:40 Q. Thank you, Helen, for dealing
14:45:46 with those.
14:45:49 The next item that I am going to
14:45:50 deal with is an item with a resident that I
14:45:54 know that you know very well.
14:45:57 A. Uhm-hmm.
14:45:57 Q. And again, I just want to

14:45:59 remind both of us not to use the resident's
14:46:02 name. Okay?
14:46:03 A. Yes.
14:46:03 Q. All right. And so if I can
14:46:07 take you to tab number R, which is document
14:46:12 number 00522.
14:46:20 A. Yes.
14:46:20 Q. This is a Critical Incident
14:46:25 Report. We have gone over it yesterday with
14:46:28 Ms. Van Quaethem. It is dated January 30th,
14:46:34 2012 -- submitted January 30th, 2012, but dated
14:46:39 January 12th, 2012.
14:46:41 Now, before we get into the
14:46:44 incident, and without providing us with any
14:46:46 personal identifiers, did you know this
14:46:51 resident?
14:46:51 A. Yes.
14:46:52 Q. And what type of relationship
14:46:55 did you and she have?
14:46:56 A. We had a very good
14:46:57 relationship. I had gotten to know her in the
14:47:01 retirement home when she lived there. She
14:47:07 turned 62 this year in December, and I knew her
14:47:13 before, a couple of years at least before her
14:47:18 40th birthday because I remember Bonnie Hughes,
14:47:24 who was the retirement home manager at the
14:47:26 time, giving her a birthday party for her 40th
14:47:30 birthday in the retirement home because she
14:47:34 felt there was not a lot of family support.
14:47:39 And this resident would walk the
14:47:42 hallway until she found someone to complain to,
14:47:46 and I had an open-door policy and she would

14:47:50 1 come in and talk to me.
14:47:51 2 Q. All right. You identify
14:47:54 3 within paragraph 116 of your affidavit, and I
14:47:58 4 understand this particular resident was in and
14:48:01 5 out of the long-term care a couple of times,
14:48:04 6 but you indicated that while she was on the
14:48:06 7 retirement side, to assist her financially you
14:48:10 8 would take her clothes home and wash them
14:48:13 9 yourself; is that true.
14:48:17 10 A. That's correct. She would
14:48:18 11 come and complain to me and she would have the
14:48:21 12 article of clothing with her, and, you know, it
14:48:25 13 was either shrunk or stained that she couldn't,
14:48:32 14 you know, wear it. And I felt bad for her.
14:48:38 15 And, I mean, she complained several times and,
14:48:41 16 you know, one time she was crying, and my girls
14:48:48 17 were older and I thought I could manage, you
14:48:50 18 know, to do her laundry, so we made that
14:48:52 19 arrangement. I offered to do it for her. And
14:48:58 20 I would take her clothing home on a Friday and
14:49:00 21 bring it back to her Monday or Tuesday.
14:49:01 22 Q. All right.
14:49:03 23 A. And I would hand-wash them, I
14:49:05 24 would do stain removal, and I would hang them
14:49:09 25 to dry so that they would last longer.
14:49:12 26 Q. All right. Now, you indicate
14:49:16 27 that she had a fairly -- in your affidavit at
14:49:19 28 paragraph 118, that she had a fairly strong
14:49:22 29 personality and she didn't necessarily follow
14:49:27 30 all the rules; is that true?
14:49:28 31 A. That is true.
14:49:28 32 Q. All right. So I want to take

14:49:30 1 you to January 2012, and by this time you
14:49:35 2 indicate in your affidavit that she has gone
14:49:37 3 from retirement to the home side, out to the
14:49:42 4 community and back to long-term care?
14:49:44 5 A. Yes.
14:49:45 6 Q. So in 2012 an incident occurs
14:49:49 7 on January the 12th, and, as I said, I don't
14:49:54 8 want to go through the full document, but I
14:49:56 9 just do want to ask you a couple of questions.
14:50:01 10 And in essence it says under "Description of
14:50:04 11 the incident" that:
14:50:07 12 "At 00:30, resident went to
14:50:11 13 nurses' station. Resident had a
14:50:13 14 stuffed nose and a hoarse voice.
14:50:15 15 Replied that she had been
14:50:16 16 coughing when asked by B.
14:50:17 17 Wettlaufer, RN. RN asked her to
14:50:19 18 return to her room as she was
14:50:21 19 contagious. Resident did so
14:50:22 20 without incident but came to
14:50:24 21 desk at 01:15 with her coat on
14:50:29 22 saying she was leaving facility.
14:50:31 23 Resident signed herself out and
14:50:32 24 left the building. Resident
14:50:34 25 reported to H. Crombez, DON that
14:50:38 26 B. Wettlaufer, RN slapped her as
14:50:40 27 she was leaving the building."
14:50:42 28 So my understanding from the
14:50:43 29 document is that this particular resident told
14:50:45 30 you that that morning that this had happened
14:50:48 31 the night before?
14:50:48 32 A. Yes.

14:50:49 Q. Now, what are your
14:50:53 obligations as a facility when a resident comes
14:50:57 and identifies to you that she has been slapped
14:51:00 by a Registered Nurse?
14:51:02 A. Well, we are to report it.
14:51:08 Our procedure was to investigate incidents
14:51:15 first and then report.
14:51:17 Q. That was your practice, was
14:51:20 it?
14:51:20 A. That was our practice, yes.
14:51:21 Q. And in this particular issue,
14:51:25 the evidence indicates that went through with
14:51:29 Ms. Van Quaethem that the resident came back
14:51:32 and apologized on January the 16th, I believe,
14:51:40 but then called the Ministry herself. Is that
14:51:43 your recollection?
14:51:44 A. Yes.
14:51:44 Q. Now, why in this particular
14:51:48 case, based upon -- and I guess, number one,
14:51:52 did you investigate?
14:51:53 A. Yes, we did. We asked the
14:51:57 resident to come to the Administrator's office
14:52:01 and we talked to her. And Brenda asked her to
14:52:08 demonstrate how she was hit and to try and use
14:52:14 the same amount of force as was used by Bethe
14:52:23 against her.
14:52:24 Q. And did the resident do that?
14:52:25 A. She had complained that she
14:52:30 had been slapped, and she said that several
14:52:33 times. And what she demonstrated to Brenda,
14:52:38 you know, was a punch and it wasn't -- you
14:52:42 know, it wasn't a slap. And we had had

14:52:51 1 experience with Christine not --
14:52:53 2 Q. Sorry, no names.
14:52:54 3 A. Oh, sorry.
14:52:55 4 Q. That is okay, but just --
14:52:58 5 A. We had experience with her
14:52:59 6 that she didn't always tell the truth.
14:53:02 7 Q. All right. And on this
14:53:06 8 particular occasion, is that the conclusion
14:53:08 9 that you came to?
14:53:08 10 A. Yes.
14:53:09 11 Q. So you did not report it to
14:53:11 12 the Ministry?
14:53:11 13 A. That's correct.
14:53:12 14 Q. Now, my understanding, having
14:53:16 15 gone through the documents in the last couple
14:53:19 16 of days with Brenda, is that on February the
14:53:26 17 8th, 2012, this resident complained again that
14:53:32 18 Bethe Wettlaufer had come into her room and hit
14:53:35 19 her on her left frontal shoulder to wake her up
14:53:38 20 to do her blood sugar.
14:53:41 21 And so did you report that right
14:53:42 22 away?
14:53:43 23 A. I did, because I felt she
14:53:48 24 would call the Ministry herself if she didn't
14:53:51 25 -- if I didn't do that.
14:53:52 26 Q. Now, before I finish on this
14:53:53 27 area, the one question that I have is -- I
14:54:02 28 guess it is more than one, as usual with most
14:54:04 29 lawyers. Was there any training of yourself as
14:54:09 30 to when you were required and under what
14:54:13 31 circumstances to report abuse to the Ministry?
14:54:17 32 A. I believe there was.

14:54:19 Q. And how often would you get
14:54:21 that training?
14:54:22 A. We had the initial training
14:54:31 and then we would review our abuse policy every
14:54:35 year.
14:54:35 Q. All right. And in any part
14:54:40 of that training, did they identify that you
14:54:43 can do your own investigation, and if you
14:54:46 conclude it didn't happen, then you shouldn't
14:54:48 report to the Ministry?
14:54:50 A. Well, that was -- that was my
14:54:56 belief at the time, yes.
14:54:57 Q. So if this resident had not
14:55:02 called the Ministry herself, the Ministry would
14:55:05 not have known that there was an allegation
14:55:07 that she had been slapped?
14:55:08 A. That's correct.
14:55:09 Q. Now, you said that was your
14:55:12 understanding at the time?
14:55:13 A. Yes.
14:55:13 Q. Did that understanding ever
14:55:15 change?
14:55:15 A. Yes. We had an annual
14:55:19 inspection in 2000 and -- I forget now, I have
14:55:28 it in my affidavit, I just forget the year.
14:55:32 And the inspector said to both Brenda and I
14:55:42 that it would be to our benefit to report
14:55:45 things immediately before investigating, and
14:55:51 that is not how we had looked at it before.
14:55:58 Q. All right. And are you aware
14:56:00 as to whether the Ministry actually came in and
14:56:02 investigated it once they got the Incident

14:56:05 1 Reports?
14:56:07 2 A. I don't believe they did.
14:56:12 3 There was a phone call, I think.
14:56:14 4 Q. All right. And before we
14:56:17 5 leave this subject, there is a Disciplinary
14:56:21 6 Action Form for Bethe Wettlaufer dated February
14:56:25 7 22nd, 2012, at Exhibit T, document number
14:56:37 8 16840.
14:56:40 9 A. Yes.
14:56:40 10 Q. And it identifies that she is
14:56:56 11 given a counselling with notice. Can you
14:57:04 12 identify for us what the incident was?
14:57:06 13 A. She had an:
14:57:09 14 "Inappropriate conversation with
14:57:10 15 a resident regarding telling her
14:57:13 16 [she] would not longer stand for
14:57:15 17 being bullied."
14:57:18 18 And I told her that this was
14:57:19 19 inappropriate, as you are the registered staff
14:57:22 20 and need to remain calm and professional at all
14:57:27 21 times.
14:57:27 22 Q. And you indicate in your
14:57:28 23 affidavit that this may have involved the same
14:57:30 24 resident that claimed that Elizabeth Wettlaufer
14:57:36 25 had slapped?
14:57:36 26 A. Yes, I believe that is true.
14:57:37 27 Q. And I didn't see that
14:57:45 28 particular allegation that Elizabeth Wettlaufer
14:57:48 29 had had an inappropriate conversation with a
14:57:52 30 resident; I didn't see it referenced in any of
14:57:54 31 the Critical Incident Reports that you filed.
14:57:55 32 Was there a reason that it wouldn't be included

14:58:00 1 in either the first report or an amendment
14:58:03 2 later?
14:58:04 3 A. I think I just didn't think
14:58:08 4 of it.
14:58:08 5 Q. All right. How did the
14:58:11 6 situation end up, without using any either
14:58:15 7 family names or identifiers or the resident's
14:58:18 8 name? How did it resolve itself between
14:58:23 9 Elizabeth and this particular resident, if at
14:58:25 10 all?
14:58:26 11 A. Well, this resident never
14:58:31 12 particularly liked Bethe, but I believe they
14:58:38 13 had a satisfactory relationship.
14:58:48 14 Q. Was there --
14:58:49 15 A. She wasn't -- I think we
14:58:53 16 moved her -- I believe we moved the resident to
14:58:58 17 East Wing, so then Bethe wouldn't be her
14:59:06 18 immediate nurse and she wouldn't have such
14:59:15 19 close interaction with her, unless it happened
14:59:19 20 on night shift.
14:59:19 21 Q. Your affidavit indicates that
14:59:22 22 there -- and this is at paragraph number 130:
14:59:29 23 "These issues were resolved at a
14:59:31 24 family meeting February 24,
14:59:34 25 2012. Elizabeth Wettlaufer was
14:59:35 26 there. They apologized to each
14:59:37 27 other and goals were set. After
14:59:39 28 the meeting the resident asked
14:59:41 29 the Ministry not to come in."
14:59:43 30 Is that your recollection?
14:59:44 31 A. Yes, from the documentation,
14:59:48 32 yes.

14:59:48 Q. Now, my understanding from
14:59:51 your affidavit is that the resident moved out
14:59:53 of the home shortly thereafter?
14:59:55 A. Yes.
14:59:58 Q. I know, it is very hard. The
15:00:01 resident.
15:00:01 A. She was not happy in the
15:00:05 home, and she had, you know, many complaints.
15:00:10 She didn't like the meals, we used too much
15:00:14 onion, she didn't enjoy the activities.
15:00:20 Q. All right, so she left --
15:00:21 A. There was quite a list.
15:00:23 Q. -- the facility?
15:00:25 A. Yes, she left the facility,
15:00:28 and, you know, that was a bit of a process. I
15:00:30 really wanted it to work for her, because I had
15:00:33 tried it once before and it didn't work because
15:00:41 she couldn't manage her own money.
15:00:43 So I talked to her older sister,
15:00:44 who lived quite a distance away --
15:00:46 Q. Okay, I am just going to --
15:00:48 I know you have a lot of information about this
15:00:49 particular resident, so I'm going to phrase it
15:00:53 this way.
15:00:54 Did you -- after she left and
15:00:56 you assisted her with those types of personal
15:00:58 things, did you and her remain in contact?
15:01:00 A. Yes.
15:01:01 Q. And would you see each other?
15:01:03 A. Yes.
15:01:03 Q. And what are the types of
15:01:05 things that you would see each other for?

15:01:07 A. We would go out for supper.
15:01:09 We would go shopping.
15:01:16 Q. All right.
15:01:17 A. She had tickets to a play and
15:01:21 she invited me to accompany her, like at the
15:01:29 Woodstock Theatre. And, yeah, we did lots of
15:01:36 things.
15:01:36 Q. All right. So that was in a
15:01:41 period between January 12th, 2012, and the
15:01:45 family meeting, as we understand it, is
15:01:47 February 24th, 2012. The documents indicate
15:01:51 that there were other issues being raised in
15:01:56 January 2012 about Bethe Wettlaufer. Do you
15:01:58 remember there being some issues?
15:02:00 A. I can't recall them without
15:02:06 looking at them.
15:02:07 Q. All right. Well, we'll go
15:02:08 through them.
15:02:09 First of all, there's some
15:02:17 documents that are dated, and I won't take you
15:02:22 to them for a minute, Amanda, but I'm going to
15:02:25 take you through some documents that were
15:02:27 received January 14th and January 15th, 2012,
15:02:42 but I noted in your affidavit and in the
15:02:44 documents there is a meeting on January 12th,
15:02:49 so before the notes came in, with Ms.
15:02:52 Wettlaufer about all these issues.
15:02:54 So do you know why you would
15:02:55 have a meeting about all these issues and then
15:02:58 receive written documentation?
15:03:00 A. Well, I think we heard about
15:03:02 it by word of mouth, or I did, and I asked the

15:03:08 staff if they knew of anything and I asked for
15:03:17 their comments.
15:03:17 Q. Okay. So if I can first turn
15:03:23 you to document number 16848, which is at your
15:03:33 Exhibit V.
15:03:37 A. B?
15:03:38 Q. "V" as in "victor."
15:03:50 Now, have you had an opportunity
15:03:52 before today to read this document?
15:03:55 A. Yes, this is not the document
15:03:58 that I was referring to when I said that we
15:04:01 heard things verbally.
15:04:03 Q. Yes, you are talking -- that
15:04:05 was the --
15:04:05 A. That was another incident
15:04:06 entirely, yeah.
15:04:08 Q. Well, this -- the document we
15:04:12 were talking about is your notes dated January
15:04:14 the 12th, but these are the documents that you
15:04:19 were receiving in January 2012?
15:04:24 A. That's correct.
15:04:25 Q. All right. So this first
15:04:27 one, you have had an opportunity to review it,
15:04:30 though, before today?
15:04:31 A. Yes, I have.
15:04:32 Q. And can you tell us from your
15:04:34 perspective -- and I read this into the record
15:04:37 yesterday. It is first about an individual
15:04:43 that was having difficulty breathing, according
15:04:44 to this person, and Bethe didn't respond to
15:04:48 assess the resident for a couple of days.
15:04:51 And then another incident about

15:04:55 1 somebody ringing for Bethe and she didn't
15:04:58 2 respond, et cetera.
15:05:00 3 So tell us what this document is
15:05:01 4 and what, if anything, you did about it?
15:05:04 5 A. This document, I believe, was
15:05:16 6 -- it was from a staff member, and she started
15:05:19 7 writing this on December 16th, I believe, and
15:05:26 8 then she refers to, you know, incidents that
15:05:30 9 happened back on December 5th, 6th and 7th.
15:05:36 10 So I believe the resident had
15:05:41 11 had orders, you know, since that time to look
15:05:46 12 after her oxygen needs, and I was very
15:05:55 13 disappointed in the staff member that she
15:06:00 14 hadn't reported it in a more timely fashion.
15:06:03 15 Q. Well, this staff member, what
15:06:07 16 position was she in? Was she an RN?
15:06:10 17 A. She was a PSW.
15:06:11 18 Q. All right. And who would
15:06:13 19 Bethe Wettlaufer be to her in terms of would
15:06:16 20 she be in a position of authority?
15:06:18 21 A. Yes, she would be.
15:06:19 22 Q. And so did you give any
15:06:22 23 thought to the fact it would be difficult for a
15:06:24 24 PSW to report on a Registered Nurse who is in a
15:06:28 25 position of authority?
15:06:30 26 A. Well, we were -- when we
15:06:32 27 talked to people, we were always very careful,
15:06:36 28 you know, to wait a day or two so that the
15:06:41 29 staff member wouldn't know who complained about
15:06:44 30 them.
15:06:46 31 We also told the staff member
15:06:47 32 who complained to us that we would never tell

15:06:58 1 that person who complained about them, so if
15:07:01 2 they said anything, just to say I don't know
15:07:04 3 what you are talking about.
15:07:07 4 Q. But would you agree that
15:07:09 5 there is the possibility that a PSW would be
15:07:15 6 reluctant to report anything in respect of a
15:07:17 7 Registered Nurse?
15:07:17 8 A. Well, yes, I would agree,
15:07:23 9 but, you know, residents were our number one
15:07:27 10 concern, and everyone, I felt, had a duty to
15:07:32 11 report, you know, if there was something not
15:07:35 12 right.
15:07:35 13 Q. Now, in this particular
15:07:42 14 situation they talk about the fact that a
15:07:46 15 resident started ringing at around 2:25, and
15:07:51 16 that is at the bottom of this page?
15:07:53 17 A. Yes.
15:07:54 18 Q. And they state:
15:07:58 19 "I approached Beth where she was
15:08:01 20 found sleeping in the chapel to
15:08:02 21 tell her that [the Resident]
15:08:04 22 wanted some pain meds. She told
15:08:07 23 me it would have to wait until 3
15:08:09 24 a.m. when she was finished her
15:08:10 25 break. This meant that [the
15:08:12 26 Resident] would have to be
15:08:13 27 uncomfortable for at least an
15:08:15 28 hour until the meds would even
15:08:17 29 become in effect."
15:08:24 30 Now, how would you classify Ms.
15:08:26 31 Wettlaufer's response that the resident would
15:08:30 32 have to wait for the meds until her break was

15:08:37 over?
15:08:37 A. It was totally inappropriate.
15:08:44 I would expect the Registered Nurse to get up
15:08:46 off her break and split her break and meet the
15:08:49 resident's needs.
15:08:51 Q. And sleeping in the chapel on
15:08:53 break, was that something that was allowed?
15:08:55 A. That was totally unacceptable
15:08:57 as well.
15:08:57 Q. But how would you classify
15:08:59 what she actually was doing in terms of those
15:09:01 residents that were looking for something for
15:09:04 their pain and had to wait?
15:09:07 A. Sorry, could you repeat that,
15:09:09 please?
15:09:09 Q. I guess my question is this.
15:09:13 Why wouldn't that be neglect? A resident wants
15:09:16 a pain medication and they are being told to
15:09:19 wait. In your experience, why wouldn't that be
15:09:24 classified as neglect?
15:09:30 A. It is very important when a
15:09:32 resident has pain to try and keep the pain at a
15:09:34 manageable level, and the longer you make them
15:09:37 wait, the harder it is to bring it back under
15:09:41 control. And we used to say if pain is 4, do
15:09:50 more.
15:09:51 Q. All right. And so why not
15:09:53 report this to the Ministry? Why wasn't it a
15:09:55 reportable situation?
15:09:57 A. Again, I probably didn't
15:10:03 think of it.
15:10:04 Q. Okay. Now, in around this

15:10:10 1 time as well you received a letter from
15:10:14 2 Jennifer Slyfield and this had to do as well
15:10:24 3 with a situation in which a resident was being
15:10:27 4 disimpacted. I am not going to bring it up,
15:10:30 5 Amanda. It is document, for the sake of
15:10:34 6 everyone else, document 16852.
15:10:40 7 A. Yes.
15:10:40 8 Q. And it has two things in
15:10:43 9 there. One about a resident being disimpacted
15:10:47 10 and in agony, and instead of the nurse stopping
15:10:50 11 and giving the resident a PRN for pain
15:10:52 12 medication, she just kept digging further. It
15:10:56 13 also involves a situation in which someone was
15:11:02 14 -- Bethe was paged and someone else had to
15:11:05 15 respond to a situation.
15:11:07 16 You became aware of this whole
15:11:11 17 issue of disimpacting the resident, correct, at
15:11:17 18 the time?
15:11:18 19 A. Sorry, say --
15:11:20 20 Q. You became aware that there
15:11:21 21 was an allegation?
15:11:22 22 A. Yes, yes, and I asked again
15:11:23 23 for documentation.
15:11:24 24 Q. All right. And you received
15:11:25 25 this documentation on January 14, 2016?
15:11:27 26 A. Yes.
15:11:28 27 Q. And you read it?
15:11:29 28 A. Yes.
15:11:31 29 Q. All right. Now, I am not a
15:11:34 30 Registered Nurse, far from it, so I'm not
15:11:38 31 exactly sure what is a disimpaction? If you
15:11:44 32 could just explain what the process is, what is

15:11:47 it and what is the process?
15:11:51 A. Well, normally, the PSW would
15:11:55 bring, you know, that to a Registered Nurse's
15:11:59 attention that the resident was having
15:12:02 difficulty moving their bowels and there would
15:12:07 be rectal bulging and cramping, and the
15:12:12 resident would be in distress.
15:12:15 So the nurse would respond by
15:12:20 getting her gloves and lubricant and go to the
15:12:25 room and try and assist the resident by either
15:12:34 removing some of the stool or pushing it back
15:12:38 up the bowel to reconfigure it so that it could
15:12:44 be passed.
15:12:44 Q. And what is the general
15:12:46 experience for residents when this is
15:12:48 happening?
15:12:49 A. It is quite painful.
15:12:52 Q. All right. And when you
15:12:54 viewed the document, did you come to any
15:12:57 conclusion as to -- the document and met with
15:13:01 Ms. Wettlaufer, did you come to any conclusion
15:13:03 as to the appropriate level of her care?
15:13:05 A. Well, I felt that Jennifer
15:13:13 Slyfield's comment about stopping to give a PRN
15:13:20 wasn't realistic. I would, you know, never
15:13:23 stop a bowel disimpaction to give a PRN. I
15:13:31 would try and, you know, talk to the resident
15:13:33 and try and finish what needed to be done.
15:13:37 And usually, you know, there is
15:13:39 relief with that, that the person is grateful
15:13:42 that, you know, it was done.
15:13:45 Q. And did you follow up with

15:13:48 this particular situation or make any changes?
15:13:53 A. Yes, I reviewed the bowel
15:14:03 protocol for the resident and spoke to the
15:14:10 Charge Nurse. I believe we looked at it
15:14:15 together and reviewed her bowel protocol, and
15:14:19 we had started using Lactulose for a number of
15:14:24 residents with good effect, and it was
15:14:29 something that could be adjusted as far as the
15:14:33 amount to be given and the frequency to be
15:14:37 given, you know, as the resident needed
15:14:42 adjustment, you know, with the doctor's order
15:14:47 to make it very successful for them.
15:14:55 Q. All right, thank you.
15:14:58 Commissioner, did you want to
15:15:00 take the afternoon break?
15:15:02 THE COMMISSIONER: Yes, if this
15:15:03 is a good time --
15:15:03 MS. HEWITT: Yes, thank you.
15:15:04 THE COMMISSIONER: -- for the
15:15:07 break.
15:15:07 -- RECESSED AT 3:15 P.M.
15:34:17 -- RESUMED AT 3:33 P.M.
15:34:17 THE COMMISSIONER: Go ahead, Ms.
15:34:18 Hewitt, when you are ready.
15:34:19 BY MS. HEWITT:
15:34:20 Q. Thank you, Commissioner.
15:34:21 Helen, before the break we were
15:34:24 talking about some incidents that had occurred
15:34:28 or some reports that you had received in
15:34:30 January of 2012, and I just want to take you to
15:34:34 a couple more documents on this particular
15:34:36 area.

15:34:36 And the first is document 16843, and, Commissioner, that is found at tab number X, Exhibit No. X of the affidavit. I read this in yesterday, so I don't intend to read it in again, Helen, but this was a note written by an individual named Wendy MacKnott?

A. Yes.

Q. Do you recall Wendy?

A. Yes, I do.

Q. And what position was Wendy in? Was she a PSW?

A. Yes.

Q. All right. And this particular note that we went through yesterday and the day before, it talks about a resident that had a fall?

A. Yes.

Q. And in particular I wanted to talk to you about a situation that Ms. MacKnott identifies, and that is -- well, two situations. One is that the resident was transferred, apparently transferred to the bed, and the second one was the poking of a hematoma found on the resident's leg.

Now, have you had an opportunity to review this letter?

A. Yes, I have.

Q. All right. And so maybe you can take us through -- I guess I'll ask you this. Do you remember this particular incident having occurred?

A. I remember better what

15:36:09 1 happened afterwards, but yes, I do remember
15:36:11 2 this.
15:36:11 3 Q. All right, if you can do the
15:36:12 4 best you can to provide us with your thoughts
15:36:16 5 when you would have received this letter as to
15:36:19 6 the care that was being provided by Ms.
15:36:23 7 Wettlaufer at the time, and in particular if we
15:36:29 8 talk about the poking of the hematoma with
15:36:32 9 scissors that she had obtained from the
15:36:35 10 treatment cart?
15:36:36 11 A. Yes, I didn't think that was
15:36:42 12 appropriate, but when we talked to Bethe about
15:36:48 13 it, she said, you know, she knew what she was
15:36:50 14 doing, she had had training. She also moved
15:36:57 15 the resident. And we had put out a memo that,
15:37:04 16 you know, when residents have a serious fall,
15:37:08 17 they shouldn't be moved until the ambulance got
15:37:13 18 there, but I felt that perhaps Bethe had moved
15:37:19 19 her because, you know, when you come upon a
15:37:24 20 resident who has had a serious fall, when there
15:37:29 21 is a lot of blood or, you know, trauma to the
15:37:32 22 head, you always think the worst, oh, my
15:37:35 23 goodness, they have, you know, broken their
15:37:38 24 hip; oh, my goodness, they have a head injury.
15:37:41 25 But as you work with them, you
15:37:43 26 realize that maybe this isn't as bad as what it
15:37:49 27 appears, and --
15:37:55 28 Q. Well --
15:37:56 29 A. It wasn't appropriate for
15:37:58 30 Bethe to move her, because we had put the memo
15:38:00 31 out. If she thought the hip was broken, she
15:38:07 32 should have left her on the floor. But I, you

15:38:14 1 know, I could think of, you know, myself in
15:38:17 2 situations where I had experienced a serious
15:38:21 3 fall, I remember one in particular in the
15:38:24 4 dining room, and, you know, there was a lot of
15:38:29 5 blood and maybe there wasn't a head injury
15:38:31 6 because the pressure, you know, was relieved, I
15:38:36 7 don't know. But sometimes it looks worse than
15:38:38 8 what it is.
15:38:38 9 Q. Well, let's talk about the
15:38:42 10 hematoma situation.
15:38:43 11 A. Uhm-hmm.
15:38:44 12 Q. You said that Bethe
15:38:45 13 Wettlaufer said that she has been trained and
15:38:48 14 she knew what to do, she knew what she was
15:38:51 15 doing?
15:38:51 16 A. Uhm-hmm.
15:38:52 17 Q. You are a nurse as well;
15:38:54 18 correct?
15:38:54 19 A. Uhm-hmm.
15:38:54 20 Q. And so what was your view of
15:38:58 21 what the normal practice would be if there was
15:39:01 22 a hematoma that was developing on someone's
15:39:04 23 leg?
15:39:04 24 A. The normal practice would be
15:39:06 25 to, you know, apply a cold cloth or ice, if you
15:39:10 26 could get it, to try and stop the bleeding, and
15:39:17 27 then to cover, you know, the area with an ABD
15:39:22 28 pad, which was, you know, like a one-inch pad.
15:39:26 29 It was on a roll and you could cut it off to
15:39:29 30 the size that you wanted. And then wrap that
15:39:32 31 around the leg with a cling bandage to protect
15:39:37 32 it, so that if the resident bumped it again, it

15:39:42 wouldn't break the skin.
15:39:43 Q. Now, she says that she has
15:39:45 been trained and knows what she had been doing,
15:39:50 but is it normal to puncture something without
15:39:58 sterilizing the equipment first?
15:39:59 A. No, it certainly is not.
15:40:01 Q. All right. And in that same
15:40:05 letter Ms. MacKnott talks about the fact that
15:40:08 she had brought to Ms. Wettlaufer's attention
15:40:11 that another resident had -- appeared to have
15:40:16 some sort of a wound on her fingers and that it
15:40:20 was bleeding?
15:40:21 A. Yes.
15:40:21 Q. And had asked Ms. Wettlaufer
15:40:22 to assess that particular resident?
15:40:25 A. Uhm-hmm, that's correct.
15:40:26 Q. Did she assess that resident?
15:40:27 A. No, she didn't.
15:40:29 Q. All right. And in those two
15:40:31 instances, there wasn't a report -- there was a
15:40:37 report to the Ministry in respect of the
15:40:39 resident's fall and transfer to hospital;
15:40:42 correct?
15:40:42 A. That's correct.
15:40:42 Q. But there was no reports to
15:40:44 the Ministry in respect of the treatment that
15:40:46 they received?
15:40:46 A. That's correct. And, you
15:40:51 know, after reviewing the documentation, I
15:40:55 assumed, I think, that the puncture wound or
15:40:59 the popping wound was the smaller of the two
15:41:03 wounds, and, you know, that healed very well.

15:41:07 Q. And the wound that had led, I'm assuming, to the blood on the floor, did that heal well or did it not heal well?
15:41:20 A. No, it did not heal well, and you know, there was a lot of blood on the floor, so I think I assumed it was the larger of the two. I can't explain -- you know, I was watching this resident closely. She had gone to hospital and came back saying that there was no fracture.
15:41:41 And then she spent most of the day in bed, which was very unusual for her. And she did have dementia, and usually with dementia -- you know, and we did give her pain medication, I'm quite sure of that.
15:42:00 Usually with dementia, they forget that they have an injury and just resume their normal practice. And she wasn't moving. And, you know, she was eating, you know, fairly well and drinking fairly well, and I would go and see her at different times of the day just to check on her.
15:42:28 And I was beginning to think that maybe the x-ray missed something, because she wasn't moving. And I had had the experience in the past with a cognitive resident who had had a fall and who we sent back to hospital three or four times, you know, over several months because she would cry to me and say, Helen, there is something wrong. I have never had pain like this before.
15:43:00 And we finally, you know, with

15:43:09 repeated x-ray found that she had a pelvic
15:43:12 fracture. And I was starting to think that
15:43:13 perhaps the same thing had happened to this
15:43:16 resident, that, you know, the x-ray missed
15:43:17 something.
15:43:18 And I was talking to one of the
15:43:21 other -- or one of the RPNs who was our skin
15:43:26 care person, and I asked her, you know, how
15:43:29 that wound was healing, and, you know, I asked
15:43:36 her about the right one because I thought that
15:43:39 was the puncture one, and she said, oh, she
15:43:42 said, that looked, you know, good on the first
15:43:45 day, she said, the day after, she said. And
15:43:49 then she kind of thought, she said it was
15:43:51 completely healed in three days, and I think
15:43:53 this must have been about day four.
15:43:55 And she asked me, do you want
15:43:56 her to go back to hospital? Because I
15:44:00 explained what I was thinking. And I said,
15:44:02 well, let's give it another day or two. And
15:44:05 then by the fifth day she started, you know,
15:44:08 being more herself, getting up, you know, and
15:44:14 more mobile.
15:44:15 Q. All right. Now, with the
15:44:18 failure of Ms. Wettlaufer to go and examine the
15:44:21 other resident's finger, maybe you can just
15:44:26 educate the Commissioner and I as to your
15:44:29 mandatory obligations to report neglect or
15:44:33 incompetent treatment. What is the definition
15:44:36 of "neglect"? What did you see would rise to
15:44:40 the level that would need to have mandatory
15:44:43 reporting?

15:44:43 A. Well, neglect is, you know, not doing something that you should do for a resident. And I don't know. You know, I don't know if I had a mental block about neglect, but I really didn't think of it, as far as I can, you know, recall.

15:45:11 Q. And correct me if I'm wrong, but is the reporting a neglect that results in harm or serious risk of harm to the resident?

15:45:19 A. Yes.

15:45:19 Q. And how do you determine what -- well, it wouldn't have been harm, because the resident was harmed already, but what did you use as your threshold to determine that something would be a serious risk of harm to the resident?

15:45:37 A. Well, sometime I think in, you know, about the middle of 2012, we were given some education on this, and they were decision trees.

15:45:52 Q. And is that what you went by, these decision trees?

15:45:57 A. I can't recall if I -- we looked at them often, Brenda and I, but I can't recall whether I looked at it for this incident.

15:46:06 Q. Okay, I think -- if I can just have one moment, Commissioner.

15:46:13 THE COMMISSIONER: Yes.

15:46:14 MS. HEWITT: If I could ask that document 16542 be put on the screen. That is in the Overview

15:46:31 Report, Commissioner. It is not
15:46:32 in your exhibit book.
15:46:36 THE COMMISSIONER: All right,
15:46:37 thank you.
15:46:38 BY MS. HEWITT:
15:46:38 Q. It may be a little bit
15:46:39 difficult to read. We may have to zoom in.
15:46:51 Now, this document at the bottom
15:47:01 is dated May 2012. Oh, thank you very much. I
15:47:08 can actually read this version. Do you see
15:47:10 that document?
15:47:11 A. Yes, I do.
15:47:12 Q. And is this the decision tree
15:47:14 that you are referring to?
15:47:15 A. Yes, it is.
15:47:16 Q. All right. And so maybe you
15:47:21 can simply help take us through it, because you
15:47:23 would be more familiar with this document than
15:47:25 we would.
15:47:26 A. So starting at the top, it is
15:47:33 "Alleged, suspected or witnessed neglect of a
15:47:36 resident by licensee or staff," and to the
15:47:44 right it says:
15:47:46 "Licensee to immediately
15:47:47 investigate and take action in
15:47:48 response to the incident."
15:47:51 And if you go towards the
15:47:56 bottom:
15:47:57 "Are there reasonable grounds to
15:47:58 suspect that neglect has
15:48:00 occurred or may occur?"
15:48:04 And if you read to the right, it

says:

"To determine [...]"

I am not sure what is in that dark box.

Q. It says:

"Immediately answer the following question."

And then if you go further to the right?

"Did licensee or staff fail to provide a resident with treatment, care, services or assistance required for health, safety or well-being?

Note: Can include inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

And then if the answer is yes, then we are to:

"Immediately report suspicion and inform the director (via Critical Incident Report as per memo)."

And if it is after hours, we can use the pager number.

Q. Okay. Now, this came out in 2012. Had you had training on abuse and neglect prior to 2012?

A. Oh, yes.

Q. Now, I'll take you to it in a

15:49:14 1 moment, but while we have this up, in the notes
15:49:16 2 that you have of your meeting with Ms.
15:49:20 3 Wettlaufer on January 12th, you asked the
15:49:24 4 question:
15:49:24 5 "What did you do for her? Her
15:49:27 6 index finger appeared dark and
15:49:29 7 mushy. Did you look at it?
15:49:32 8 No, I didn't get to it because
15:49:33 9 of what went on. I did the best
15:49:36 10 I could. In all honesty, I
15:49:38 11 forgot."
15:49:40 12 A. Uhm-hmm.
15:49:41 13 Q. So you had in that particular
15:49:42 14 situation in front of you Ms. MacKnott that is
15:49:46 15 saying there is a resident, there is a wound,
15:49:50 16 there is some blood, please look at it. And
15:49:54 17 you have Ms. Wettlaufer saying I didn't get to
15:49:56 18 it because of what went on that night.
15:50:00 19 A. Uhm-hmm.
15:50:00 20 Q. And we know that what went on
15:50:01 21 was a fall and a resident with a lot of blood,
15:50:04 22 et cetera, and a transfer to hospital; correct?
15:50:06 23 A. Yes.
15:50:07 24 Q. Now, when you have those
15:50:08 25 circumstances facing you, how do you answer
15:50:12 26 these questions? Do you take into account the
15:50:18 27 circumstances of the nurse, the nurse's excuse,
15:50:21 28 or simply take into account whether or not the
15:50:23 29 resident didn't receive the care on that
15:50:27 30 particular occasion that they should have
15:50:29 31 received?
15:50:29 32 A. Well, I believe I took the

15:50:31 1 nurse's, you know, situation, I kept that in
15:50:46 2 mind. And she did give Wendy instruction to
15:50:48 3 take some gauze and wrap her finger. And, you
15:50:56 4 know, I don't know, a fall is a lot of work.
15:50:58 5 You have to get a copy of the MAR. You have to
15:51:02 6 fill out the transfer form. You have to, you
15:51:04 7 know, call the family, call the doctor for a
15:51:15 8 transfer order. So there is a lot of work
15:51:18 9 involved. Plus she had her morning medications
15:51:20 10 to give.
15:51:20 11 Q. Now, if I'm reading Ms.
15:51:24 12 MacKnott's notes correctly, the fall was after
15:51:27 13 2 o'clock in the morning. Is that your
15:51:29 14 recollection?
15:51:29 15 A. Yes.
15:51:29 16 Q. So this would be the night
15:51:31 17 shift?
15:51:31 18 A. That's correct.
15:51:31 19 Q. And so the only individuals
15:51:33 20 on the night shift, I think since we looked at
15:51:36 21 that chart, would be Ms. Wettlaufer and an RPN
15:51:38 22 in terms of staffing?
15:51:39 23 A. That's correct.
15:51:40 24 Q. And Ms. Wettlaufer, from your
15:51:43 25 evidence, would be involved -- would have to be
15:51:46 26 involved with this fall; is that correct?
15:51:49 27 A. That's correct.
15:51:49 28 Q. And in retrospect, do you
15:51:55 29 have any other opinion now as to whether in
15:51:57 30 those instances, those things should be
15:51:59 31 reported or --
15:52:01 32 A. Yes, I do. I should have

15:52:06 reported it right away and investigated after.
15:52:12 Q. I do want to take you to your
15:52:14 notes with Bethe Wettlaufer on January 12th,
15:52:19 which is found, Commissioner, at tab number U,
15:52:24 document number 16853.
15:52:28 All right. And I won't go over
15:53:02 all of these because we have already referred
15:53:05 to some of it. But if I can take you to --
15:53:07 first of all, could I ask you, the only person
15:53:10 that is identified as attending on these notes
15:53:13 is Karen Routledge; is that correct?
15:53:16 A. Yes, but I was there. I was
15:53:20 the one talking. My initials are in the
15:53:24 margin, and this is Brenda's writing, and we
15:53:27 were speaking to Bethe.
15:53:28 Q. All right. So if I can take
15:53:31 you then to the second page and the question is
15:53:43 there:
15:53:43 "What did you do with left
15:53:45 hematoma. You took what and
15:53:47 punctured the skin.
15:53:49 I took scissors and poked at it.
15:53:52 Were the scissors sterile?
15:53:54 No, they were not.
15:53:56 It would have been appropriate
15:53:57 to wash the skin and apply
15:53:58 pressure."
15:54:00 Who is speaking there and
15:54:01 talking about washing the skin and applying
15:54:03 pressure?
15:54:03 A. That is myself.
15:54:04 Q. And then on the next page,

there is the items that I already talked you to about the person's finger bleeding. And then if I can take you down to the bottom of that third page, starting at "Break should be [...]"

A. Yes.

Q. "Breaks should be 1/2 or 15 minute - 2 times"

What were you referring to in that particular situation about her breaks?

A. I was just reminding her that her breaks should be either a half hour in length or, if she was interrupted, to take two 15-minute breaks or a 10-minute break and a 20-minute break, it doesn't really matter.

Q. And why did that discussion come up?

A. I can't recall off the top of my head.

Q. All right. And then it goes on to say:

"Not acceptable for residents to wait."

Who would have said that?

A. I would have said that.

Q. And the top of the next page: "I will take break separated."

Is that Ms. Wettlaufer?

A. Yes.

Q. And then if we go to the bottom of the page, it has the title "Wounds - apply pressure and cover," and then it has a night shift routine?

15:55:42 A. Yes, I reviewed the night
15:55:48 shift routine with her as an education.
15:55:50 Q. All right. And how was she
15:55:55 in this particular meeting?
15:55:56 A. I thought she was receptive.
15:56:07 You know, she talked politely.
15:56:12 Q. All right. Now, we do know,
15:56:15 and I won't take you to it, but it is document
15:56:20 number Y at 16842, that Bethe Wettlaufer then
15:56:26 -- so this meeting is January 12th. On January
15:56:28 16th, 2012, you gave her discipline, a written
15:56:34 warning, and it was for not meeting the
15:56:36 required needs of residents in a timely manner,
15:56:40 not following policy and procedure after a
15:56:42 fall.
15:56:42 So was that the result of your
15:56:45 investigation into these issues?
15:56:47 A. Yes.
15:56:47 Q. All right. So why only a
15:56:51 written warning? Why was this not serious
15:56:55 enough to do something more serious, from your
15:57:00 perspective?
15:57:00 A. Well, I'm not, you know, sure
15:57:05 without looking at a chart where we were at
15:57:07 with discipline, if it had been some time since
15:57:11 we had talked to her.
15:57:16 Q. I can help you with that,
15:57:18 because it is in the meeting or in your notes,
15:57:26 and in respect of this, this is January 16th,
15:57:29 2012?
15:57:31 A. Actually, it is right on the
15:57:32 form. She had a counselling on March the 3rd,

2011, and a verbal warning February 2nd, 2011. So we gave the next step which was a written.

Q. All right. Were you allowed to skip it if you thought it was serious enough?

A. Pardon me?

Q. Were you allowed to go to a next step, skip a step?

A. Well, after a written is a suspension, so we would need to talk to head office about that.

Q. All right. Did you think that these things were serious enough to talk to head office about a suspension at the time?

A. I don't believe so. I believe we would have if we thought it was necessary.

Q. All right. Now, we have spent quite a time going through your affidavit and you do have a lengthy affidavit with a lot of the information in it.

So I'm going to next go to a meeting that you had with Bethe Wettlaufer on September the 4th, 2012, and that is found at Exhibit BB, and, Commissioner, that is document number 16822. You see that document?

A. Yes, I do.

Q. And what was happening on this particular occasion, September 4th, 2012?

A. The refrigerator temperatures in Section B medication fridge were taken on August 27th, 29th and 31st.

15:59:42 Q. And is that one of the duties
15:59:46 of a Registered Nurse is to take the
15:59:48 refrigerator temperatures?
15:59:50 A. Yes, because it is in the
15:59:51 locked room where the, you know, medications
15:59:56 are kept in the fridge, so it was a requirement
16:00:02 by the -- for the registered staff.
16:00:06 Q. And it goes on to say:
16:00:08 "Initials on the count but not
16:00:10 with on-coming shift."
16:00:15 Do you know what you are
16:00:16 referring to there?
16:00:17 A. Well, it looks like, you
16:00:21 know, she was counting incorrectly.
16:00:24 Q. And is this a narcotic count?
16:00:26 A. It would be the shift count,
16:00:29 I think. It is "initials on the count but not
16:00:34 with on-coming shift."
16:00:41 Q. Well, if we go two-thirds of
16:00:43 the way down, it says:
16:00:45 "What is the proper procedure on
16:00:47 coming count", something, "in
16:00:53 counted, both watching - pills
16:00:56 and what is written, watch what
16:00:59 is put back in the box.
16:00:59 Expected all proper process
16:01:02 followed by Reg. Staff. Helen
16:01:03 gave Bethe written warning."
16:01:06 That is not the narcotic count?
16:01:08 A. I think it is --
16:01:11 Q. I am going to --
16:01:13 A. I think this is shift count,

16:01:14 because "both watching," you know, she says --
16:01:19 Q. I'm going to stop you there,
16:01:20 Helen, and only because let's go to the
16:01:23 discipline, 16821. That might assist you.
16:01:27 Do you see that?
16:01:39 A. "Not counting narcotics as
16:01:48 per protocol on Monday [...] and
16:01:52 not taking med refrigerator
16:01:54 temperature on Friday [...] and
16:01:58 vaccine frig" on those three
16:02:02 other dates.
16:02:03 Q. Does that help in determining
16:02:04 what those notes were referring to? So these
16:02:16 notes that we were just referring to are dated
16:02:19 September 4th, 2012?
16:02:22 A. Uhm-hmm.
16:02:23 Q. And the discipline is
16:02:25 September 4, 2012?
16:02:30 A. Yeah, this is the narcotic
16:02:32 count at change of shift.
16:02:34 Q. Yes, okay, all right. I'll
16:02:37 move on then.
16:02:38 And she was given on this
16:02:43 particular day a written warning?
16:02:44 A. That's correct.
16:02:44 Q. All right. And in or around
16:02:47 that same time, there is another discipline,
16:02:51 this time it is August 31st, for not assessing
16:02:57 a resident as required, and this is at this
16:03:00 same tab. I'm not going to take you to it.
16:03:02 But I am going to take you to
16:03:04 the minute, or the meeting, which is at

16:03:07 document 16826. Do you see those notes?
16:03:23 A. Yes.
16:03:26 Q. All right, and it says:
16:03:28 "Why did you not respond to
16:03:31 Trish Brown's concern regarding
16:03:34 [Resident].
16:03:35 Told in report regarding swollen
16:03:36 left cheek.
16:03:39 Had seen her [...]"
16:03:41 What is that word?
16:03:42 A. Twitching, I think.
16:03:44 Q. "We had concerns with your
16:03:45 charting previously on August
16:03:48 8/12 and how you handled."
16:03:51 And it goes down to two-thirds
16:03:53 of the way down the page:
16:03:54 "Took keys home.
16:03:57 OCD and bipolar - changing
16:04:02 meds."
16:04:03 Then it says:
16:04:05 "Your assessment skills are not
16:04:06 up to par.
16:04:07 Documentation."
16:04:10 Is that Ms. Wettlaufer
16:04:10 identifying any issues to you?
16:04:12 A. Yes, she took the keys home
16:04:24 and she was telling us that she had OCD and
16:04:24 bipolar and that her doctor was changing her
16:04:27 medication.
16:04:28 Q. And when you say she took the
16:04:32 keys home, what keys would those be?
16:04:35 A. Those would be the keys to

16:04:37 the med room.
16:04:38 Q. The keys that she is supposed
16:04:43 to provide to the on-coming nurse?
16:04:44 A. Yes.
16:04:45 Q. All right, and at this time,
16:04:47 did she ask for any accommodation?
16:04:49 A. No, she did not.
16:04:51 Q. And did you discuss putting
16:04:56 her on a leave of absence or asking for any
16:04:58 documentation from her doctor yourself?
16:05:00 A. Well, we did talk to her. If
16:05:10 you could scroll down, I think we talked to her
16:05:11 about:
16:05:20 "Reg staff have a standard and
16:05:22 these are services [...],"
16:05:30 "these [serve as] [sic]
16:05:32 deficiencies."
16:05:33 Q. Or is that "these are serious
16:05:36 deficiencies"?
16:05:37 A. And "these are serious
16:05:39 deficiencies," yes.
16:05:40 Q. If I could take you to
16:05:42 document 16823. So this is the discipline.
16:05:59 And within this notice, it states:
16:06:02 "Written warning with notice
16:06:03 that continued poor performance
16:06:05 will result in disciplinary
16:06:06 action up to and including
16:06:08 termination. If continued poor
16:06:09 work performance related to
16:06:10 health issues continue,
16:06:12 consideration may be given to

16:06:13 report to the College of Nurses
16:06:14 for 'fitness to practice for
16:06:17 review' your health and
16:06:20 well-being is at our [ut]most
16:06:25 concern. Please follow-up with
16:06:27 the medical issues you discussed
16:06:29 with us."
16:06:31 So educate us as to what is a
16:06:34 fitness to practice review?
16:06:36 A. It is a review by the College
16:06:42 of Nurses to see if a registered member is in
16:06:45 fact fit to practice.
16:06:46 Q. And is that available to you
16:06:56 at any time?
16:06:57 A. I believe so.
16:06:58 Q. And is that the same thing as
16:07:02 reporting someone to the College of Nurses,
16:07:07 such as on a termination?
16:07:08 A. I don't think it is the same
16:07:12 as reporting. I think it is, you know, asking
16:07:15 for help.
16:07:16 Q. All right. And so by this
16:07:19 point in time why wouldn't you simply refer Ms.
16:07:25 Wettlaufer to the College of Nurses for this
16:07:29 fitness to practice review?
16:07:30 A. I think we were hoping to
16:07:36 make an impression that she would, you know,
16:07:41 change her behaviour.
16:07:43 Q. And on the bottom left-hand
16:07:45 side it says:
16:07:46 "Explained to Bethe that she
16:07:49 brought her health issues to us

16:07:51 and we are obligated to ensure
16:07:53 the safety of the Residents."
16:07:57 A. Yes.
16:07:57 Q. What did you mean by that?
16:07:59 A. Well, she told us that she
16:08:07 had issues with her medication change. I think
16:08:14 she used that as a reason for her performance.
16:08:22 And we wanted her to self-reflect, and if she
16:08:28 thought that she wasn't up to par, then, you
16:08:32 know, she should ask for a leave of absence.
16:08:35 Q. Why leave it in her hands to
16:08:38 self-reflect as to whether she wasn't up to par
16:08:41 versus your putting her off on a leave of
16:08:44 absence?
16:08:44 A. I don't know. I can't
16:08:52 recall.
16:08:52 Q. Did you ever refer her for a
16:08:56 fitness to practice review?
16:08:58 A. No, we did not.
16:08:59 Q. Okay. So I want to then go
16:09:05 to some issues that you had in terms of her
16:09:10 medications -- sorry, medication incidents, not
16:09:15 her medications.
16:09:16 And we have already dealt with
16:09:19 quite a few today, and if we go to -- I'll just
16:09:28 orient you, Helen, in your document as to the
16:09:38 paragraph that we are at.
16:09:40 So if we turn to paragraph 185
16:09:51 of your affidavit, it lists out how you
16:09:57 counselled or disciplined Elizabeth Wettlaufer
16:10:00 for her medication errors, and we have been
16:10:02 through quite a few and I know your affidavit

16:10:05 1 does refer to others.
16:10:13 2 A. Yes.
16:10:13 3 Q. And I am just waiting for it
16:10:15 4 to come up. So paragraph 185, approximately
16:10:20 5 page 38. You have got 138 as the page number.
16:10:38 6 MS. STRATTON: Sorry, I'm just
16:10:43 7 going to refresh.
16:10:51 8 BY MS. HEWITT:
16:11:19 9 Q. We seem to be having
16:11:21 10 technical difficulties. You are at paragraph
16:11:25 11 185 in your document?
16:11:26 12 A. Yes, I am.
16:11:27 13 Q. So we see, and we saw this
16:11:28 14 yesterday through Brenda, that by 2013 the
16:11:35 15 incidents are being met with a written notice
16:11:38 16 in February 2013, a one-day suspension in March
16:11:43 17 2013, a five-day suspension in April 2013, and
16:11:49 18 we heard evidence yesterday that that was
16:11:52 19 grieved and then withdrawn.
16:11:54 20 So I want to start with you at
16:11:56 21 the letter of counselling that is found at --
16:12:05 22 that is December the 19th, 2013. And that is
16:12:16 23 found at tab number OO, document number 16775.
16:12:49 24 A. Sorry, it is OO.
16:12:51 25 Q. It is OO, and it is the last
16:12:53 26 page in that particular tab.
16:12:55 27 A. Sorry.
16:13:03 28 Q. And this document indicates:
16:13:07 29 "This letter is to inform you
16:13:08 30 that you are not working to the
16:13:09 31 best of your ability. A
16:13:11 32 resident's family complained

that you administered two types of eye drops at the same time. At the investigation meeting held today you admitted to doing this stating you knew it was wrong. The one eye drop was scheduled for 16:30 and the other at 20:00 p.m. You confirmed you administered both at approximately 18:30 p.m. The family member has concerns for her husband's eye condition and knew the drops were administered wrong."

And then at the bottom it states:

"Bethe, we want you to take the above seriously. We cannot continue to have a good working relationship [...] "

Now, do you remember this particular incident?

A. After reviewing the documentation, yes.

Q. And this document indicates that Ms. Wettlaufer actually knew that she was administering it wrong, not that she made a mistake and later found it, but she knew at the time that she was doing it that it was wrong?

A. Yes, she did admit that.

Q. And we just saw that you were up to a five-day suspension in April of 2013,

16:14:22 1 and so can you explain why now in December of
16:14:27 2 2013 the next step which would be termination
16:14:30 3 was not followed?
16:14:31 4 A. I think Brenda and Wanda
16:14:39 5 discussed it, and it being the Christmas
16:14:43 6 season, because it sounds like we, you know,
16:14:48 7 investigated first and then called her back in,
16:14:56 8 because it says "at the investigation meeting
16:14:58 9 held today, you admitted," and then we gave her
16:15:03 10 this letter as a counselling with a strong
16:15:15 11 statement saying that, you know, she needed to
16:15:19 12 improve and that we couldn't continue to have a
16:15:26 13 good working relationship if these issues
16:15:28 14 continued.
16:15:29 15 Q. Okay. And in respect of that
16:15:34 16 particular situation, and I will take you to
16:15:38 17 the document if you wish, Helen, but there was
16:15:45 18 notes taken at a meeting with Bethe Wettlaufer,
16:15:50 19 Jennifer Hague, Helen and Brenda, so yourself
16:15:53 20 and Brenda, and those notes say the following:
16:15:57 21 "We are going to put this on
16:15:58 22 your file, very serious issues,
16:16:04 23 with the Christmas season, if we
16:16:07 24 sent this to HO the outcome
16:16:09 25 wouldn't be good."
16:16:13 26 Do you see that document?
16:16:14 27 A. Yes.
16:16:14 28 Q. Now, can you talk to us or
16:16:16 29 shed any light on by what is meant by those
16:16:18 30 particular comments?
16:16:19 31 A. Well, I think we did, you
16:16:23 32 know, say that to her, but then after the

16:16:26 meeting we reconsidered and sent it to -- or
16:16:33 Brenda talked to Wanda, because we didn't do
16:16:38 letters. We used our forms.
16:16:41 Q. So that letter, your
16:16:45 recollection of who drafted that letter is what
16:16:47 then?
16:16:48 A. That it came from Wanda at
16:16:51 head office, or that she had -- you know, she
16:16:55 sent it over to us and that is what we used.
16:17:01 Q. All right. Now, the next
16:17:06 incident with Ms. Wettlaufer that I want to
16:17:11 take you to is in January of 2014, so in this
16:17:15 particular time she is given a five-day
16:17:20 suspension. Do you remember that?
16:17:21 A. Yes.
16:17:24 Q. And part of why she is
16:17:28 suspended at that point in time, as I
16:17:31 understood it, involved Maureen Pickering; do
16:17:34 you remember that? That is one of our --
16:17:38 A. I would like to see the
16:17:39 documentation again.
16:17:39 Q. Yes, absolutely. So first
16:17:42 I'll take you to the termination letter, so you
16:17:46 can -- or the discipline letter so you can just
16:17:47 refresh your memory as to the discipline. That
16:17:51 is in tab number PP, document 16739.
16:18:11 And it says:
16:18:15 "This letter is to inform you
16:18:16 that you are not working to the
16:18:18 standards required for Caressant
16:18:19 Care. A resident was given
16:18:25 medication outside of the

16:18:26 allowable time frame, this same
16:18:28 resident was spoken to in an
16:18:30 inappropriate manner that
16:18:31 resulted in upsetting the
16:18:33 resident and you failed to
16:18:34 document the interventions that
16:18:36 you said you tried for this
16:18:38 resident. All of these issues
16:18:40 are being brought to your
16:18:41 attention. Please reflect on
16:18:42 your actions."
16:18:46 And then she is given a five-day
16:18:48 suspension. And in your affidavit at paragraph
16:18:51 214, page 43, you state:
16:18:55 "One of these incidents involved
16:18:57 one of Elizabeth Wettlaufer's
16:18:59 victims, Mrs. Pickering. The
16:19:02 Respirodone was supposed to be
16:19:04 given in the morning and instead
16:19:05 she gave it on evening shift."
16:19:07 Does that help at all?
16:19:09 A. Yes.
16:19:10 Q. All right. And do you
16:19:12 remember what incident or what Ms. Wettlaufer
16:19:19 said when it identifies "the resident was
16:19:25 spoken to in an inappropriate manner"?
16:19:27 A. She told the resident that
16:19:30 she had Alzheimer's and that she couldn't
16:19:35 remember things and, you know, she had to trust
16:19:40 the staff, or something to that effect.
16:19:41 Q. All right. If I can take you
16:19:43 to document 17034, and again, I know this

16:19:50 1 involves a resident, so I apologize to the
16:19:53 2 families that may be -- her family that may be
16:19:57 3 watching, but it is relevant, Commissioner.
16:19:59 4 If we go down to the description
16:20:03 5 of the unusual occurrence:
16:20:10 6 "Resident finished antibiotic
16:20:11 7 for urine infection January
16:20:13 8 16/14. Since then, behaviours
16:20:15 9 have been escalating. 1/20/2014
16:20:19 10 Tylenol 500 mg. tab [...]"
16:20:24 11 It talks about what she was
16:20:25 12 given and then it says:
16:20:26 13 "At 15:25, resident wandered
16:20:30 14 into Room 113 and was assisted
16:20:32 15 out x 2 in 5 minutes. When RN
16:20:36 16 asked her to stay out of
16:20:37 17 resident's room, she denied
16:20:39 18 being in it. RN attempted to
16:20:40 19 explain that she was forgetful
16:20:42 20 and needed to trust staff,
16:20:44 21 resident grabbed RN's hand,
16:20:46 22 squeezed it and yelled angrily,
16:20:49 23 'I don't forget.'"
16:20:53 24 Is that what you were referring
16:20:54 25 to?
16:20:54 26 A. Yes.
16:20:54 27 Q. All right. And so Ms.
16:20:57 28 Wettlaufer received a five-day discipline in
16:21:00 29 January 2014; is that correct?
16:21:08 30 A. That's correct.
16:21:08 31 Q. And our understanding from
16:21:09 32 the evidence yesterday is she grieved that

16:21:11 particular discipline?
16:21:16 A. I am not aware of that or I
16:21:18 don't recall.
16:21:18 Q. Would you be involved in the
16:21:20 grievances?
16:21:20 A. No.
16:21:21 Q. Who would that be -- who
16:21:23 would be involved in the grievances?
16:21:25 A. That would be Brenda and head
16:21:29 office.
16:21:29 Q. So the last thing I want to
16:21:31 -- two more things, Helen.
16:21:32 Number one is we know that in
16:21:34 March of 2014 Elizabeth Wettlaufer was
16:21:38 terminated.
16:21:39 A. Uhm-hmm.
16:21:39 Q. And briefly can you describe
16:21:41 the circumstances surrounding why she was
16:21:44 terminated on that occasion?
16:21:50 And that is -- if you want help,
16:21:52 you do touch on it at paragraph 216 of your
16:21:56 affidavit.
16:22:13 A. The resident had run out of
16:22:19 insulin after the day shift administered it,
16:22:25 and that was Agatha, and she had left the
16:22:30 resident's insulin pen open on the medication
16:22:36 cart as a reminder to herself to explain to
16:22:43 Bethe that there was no insulin for this
16:22:46 resident and, you know, that the insulin would
16:22:49 be coming and could she put it in the pen.
16:22:51 And Bethe, for whatever reason,
16:22:59 didn't follow that instruction and she borrowed

16:23:08 insulin from another resident, either believing
16:23:13 that it was the same insulin or who knows.
16:23:22 Q. She put the wrong cartridge
16:23:24 in the pen?
16:23:25 A. She put the wrong cartridge
16:23:27 in the pen and gave her the wrong insulin. And
16:23:29 that continued over the weekend until Agatha
16:23:35 came back to work I believe on Monday, and then
16:23:41 Agatha, realizing that the resident wasn't
16:23:44 feeling well and thinking back to leaving the
16:23:49 pen, you know, for Bethe to refill, checked the
16:23:56 insulin, the type of insulin in the cartridge
16:24:00 and realized it was the wrong one.
16:24:02 Q. Now, over the course of that
16:24:04 weekend, it would have been more than Elizabeth
16:24:08 Wettlaufer that administered that insulin; is
16:24:10 that correct?
16:24:10 A. Yes, that's correct.
16:24:11 Q. And did you discipline any of
16:24:14 the other nurses that were involved?
16:24:16 A. No, I did not.
16:24:17 Q. So why discipline Elizabeth
16:24:20 Wettlaufer at this time then?
16:24:21 A. Because I felt or we felt
16:24:26 that it was on Bethe's mistake. She had been
16:24:31 directed, you know, how to put -- what to do
16:24:35 with the insulin, and she didn't follow
16:24:39 direction and the insulin got -- wasn't correct
16:24:46 and the resident had side effects, if you will,
16:24:54 from getting the wrong medication.
16:24:58 Q. Now, after the termination of
16:25:01 Ms. Wettlaufer, she was reported to the College

of Nurses?

A. Yes, she was.

Q. And did you have any conversations with the College of Nurses after the report went in?

A. Yes, I did.

Q. And what were the circumstances surrounding that? Did the investigator come to speak to you?

A. She -- you know, from looking at the notes, I had received a call and she had left a message asking her to call me. I can't recall if I did call her back or if she called again, and they asked -- she asked me questions about Bethe.

Q. Was this a scheduled telephone call? Were you in your office?

A. I believe I took the call at the nurses' station in Section B.

Q. All right, and did you --

A. And I don't know, I don't remember if I went to my office or not.

Q. And did you have the file with you while you were speaking with Ms. Yee?

A. No, the file was not in the building at the time, I believe.

Q. All right. And the notes that you are referring to of Ms. Yee prepared some notes, her notes of your conversation, and you had an opportunity to review those?

A. Yes, I have.

Q. And upon your review, was

there anything within those notes that you disagreed with?

A. Yes, I --

Q. Would you like us to put them up on the screen for you?

A. Yes.

Q. So it is document number 36847. And we'll scroll down a bit. Now, we already know, just to help you, Helen, that the date of 2005 on the first line is wrong. That is actually the date, however, that is on the report to the College, it is the wrong date of hire for Ms. Wettlaufer. It should have been 2007.

But beyond that, this is Ms. Yee's notes of what she purports to have been your telephone conversation, and can you tell us from -- do you have an independent recollection now of the conversation?

A. No, I do not.

Q. So when you say there are some things you disagree with, it is not because of your independent recollection of the actual conversation?

A. I believe, you know, that there are some words missing.

Q. All right. So take us through and let us know what you believe is missing or inaccurate?

MR. SANDLER: Excuse me for a moment. I'm not quite sure what evidence is being elicited now,

because the witness says she has no independent recollection whatsoever of the conversation. I don't know how she purports to say what words are or are not missing, and I have to say, and I don't have any of this in an affidavit or a summary or anything, so I am not really in a position to respond or make fuller submissions on it. So if my friend wants to elicit this, I think it might be helpful if I could have some sense before it is elicited or what it is that the witness is going to say to see whether I would continue on with that objection. As I say, I don't have anything in a summary in relation to this whatsoever.

BY MS. HEWITT:

Q. All right. You have no independent recollection of this conversation; is that correct, Helen?

A. Well, I know, you know, some of the phrases that I used with Bethe, and I feel that is what I was telling the College.

MR. SANDLER: Well, I have made an objection, Commissioner, and I am not quite sure --

THE COMMISSIONER: I'm sorry,

16:29:30 this is what the clarification
16:29:31 is and what I understand the
16:29:33 witness now to be saying is that
16:29:34 she had standard practice in the
16:29:37 language she would use, and
16:29:39 therefore, she is reflecting on
16:29:40 her standard practice in terms
16:29:42 of what is reflected in that.
16:29:45 MR. SANDLER: All right. But as
16:29:48 I say, I don't know what this
16:29:50 evidence is going to be in
16:29:51 advance, so that is -- but in
16:29:54 any event...
16:29:55 THE COMMISSIONER: Well, why
16:29:56 don't we --
16:29:57 MS. HEWITT: Well, my friend
16:29:58 will be entitled to
16:29:59 cross-examine. We are not going
16:30:01 to get to cross-examinations
16:30:02 today, so he'll know today what
16:30:06 the evidence will be. I'm not
16:30:09 sure --
16:30:10 THE COMMISSIONER: Okay, I tell
16:30:11 you, why don't we let it go a
16:30:14 little further. That is what I
16:30:15 understood. You are right, she
16:30:16 said I don't have an independent
16:30:17 recollection, but when Ms.
16:30:21 Hewitt went back after your
16:30:22 objection, what I heard her to
16:30:24 say was I had standard language
16:30:25 that I used when I was speaking

16:30:29 with Elizabeth Wettlaufer, so
16:30:31 when I reviewed these notes, I
16:30:32 expected to see my standard
16:30:34 language coming up there.
16:30:36 So at this point what I would do
16:30:38 is I would let the witness go
16:30:39 ahead, see where we are going
16:30:41 with the questioning, and if
16:30:42 there is a problem, you stand up
16:30:43 and object again.
16:30:45 THE WITNESS: All right. So
16:30:46 where it says "she started
16:30:49 working evening shifts," you
16:30:54 know, the word "also" is missing
16:31:01 because before that she worked
16:31:03 night shifts as well, and she
16:31:04 was the only registered staff.
16:31:07 BY MS. HEWITT:
16:31:07 Q. Sorry, that --
16:31:08 A. A Registered Nurse, you know,
16:31:10 there was an RPN.
16:31:16 And then somewhere about where
16:31:20 "she was nice," you know, it was "to me" I
16:31:24 thought the words were missing, "she was always
16:31:27 nice to me."
16:31:28 Q. Sorry, let's just find out
16:31:29 where you are. How many bullet points down are
16:31:31 you referring to?
16:31:39 A. It was the last line
16:31:41 actually:
16:31:41 "She was always respectful and
16:31:42 nice to me but her practice

16:31:44 1 never changed."
16:31:46 2 Q. Okay, but other than that, is
16:31:48 3 there anything that stands out in this
16:31:52 4 conversation to you or do you recollect, after
16:31:55 5 seeing this document, I did not say that or
16:31:58 6 that is absolutely inaccurate or do you have
16:32:00 7 any recollection at all?
16:32:01 8 A. Well, when I saw, you know,
16:32:05 9 the date, I thought, you know, why would I say
16:32:13 10 that? And then when I saw -- like, I didn't
16:32:22 11 know that Brenda had only reported back 2012.
16:32:28 12 Q. Are you saying you didn't see
16:32:29 13 the report for facilities?
16:32:31 14 A. That's right, I didn't see
16:32:32 15 that, and, you know, my understanding of this
16:32:38 16 conversation is that she just wanted an
16:32:41 17 overview of what my thoughts were.
16:32:46 18 Q. So she called you -- your
16:32:48 19 recollection is you got the call, perhaps on
16:32:50 20 the floor, and this was a general overview; is
16:32:55 21 that --
16:32:55 22 A. That is correct.
16:32:56 23 Q. And then did they follow up
16:33:00 24 with you at any time after that?
16:33:02 25 A. No.
16:33:04 26 Q. All right. So I know it is
16:33:05 27 getting late, Helen and Commissioner, I only
16:33:10 28 have one more area to go in, if we can perhaps
16:33:13 29 see if we can finish Helen.
16:33:14 30 THE COMMISSIONER: How long do
16:33:15 31 you think you'll be?
16:33:16 32 MS. HEWITT: I am just going to

16:33:17 1 ask her the impact.
16:33:20 2 THE COMMISSIONER: All right, go
16:33:20 3 ahead.
16:33:21 4 BY MS. HEWITT:
16:33:21 5 Q. So, Helen, you now know what
16:33:24 6 happened in 2016. And I know you have gone to
16:33:29 7 great lengths in your affidavit to talk about
16:33:34 8 the impact, but would you like to just give
16:33:36 9 some words to the Commissioner as to what
16:33:39 10 happened when this news broke?
16:33:41 11 A. In what regard to -- it was
16:33:51 12 devastating. It was the most terrible thing I
16:33:53 13 think that could happen to anyone who works in
16:33:57 14 long-term care, who loves her residents, who
16:34:05 15 always wanted the best care possible and, you
16:34:09 16 know, thought that she worked hard to reach
16:34:14 17 those goals.
16:34:18 18 The impact to the staff was
16:34:20 19 terrible. Everybody, you know, was crying or
16:34:25 20 teary. Some, you know, had -- it affected
16:34:36 21 their life. It changed their life. It changed
16:34:40 22 my life. I haven't been the same since.
16:34:46 23 And, you know, I'm so sorry that
16:34:55 24 it happened. I can just imagine what the
16:34:59 25 families, you know, went through and what the
16:35:05 26 residents might have suffered, being given
16:35:09 27 insulin because I know it can cause, you know,
16:35:15 28 convulsions and pain and muscle spasm.
16:35:24 29 And we always -- we worked or I
16:35:27 30 worked so hard to try and teach staff about
16:35:33 31 palliative care and comfort for the residents.
16:35:41 32 We had, you know, a hospice and palliative care

16:35:45 1 in-service. You know, it was four weeks, I
16:35:49 2 think, or three weeks, I'm not -- I think it
16:35:55 3 was four weeks. And it was spaced a couple of
16:35:58 4 weeks apart so that staff could, you know,
16:36:02 5 read.
16:36:02 6 We were given the program, and
16:36:07 7 this, you know, was -- this program was
16:36:08 8 actually written by Ida Tiglar who used to come
16:36:14 9 to the home, to our meetings on a regular basis
16:36:17 10 and advise us on how to give, you know, the
16:36:21 11 correct medication and how to convert, you
16:36:25 12 know, coding to, you know, morphine, that kind
16:36:29 13 of thing.
16:36:29 14 And we offered that class, and
16:36:35 15 we had, I think, ten staff that participated,
16:36:39 16 which was really good, and we had had that kind
16:36:44 17 of training once before at the home and I took
16:36:50 18 it, you know, in the very early stages. And
16:36:53 19 then I took it again in Tillsonburg because it
16:36:58 20 was offered there at a convenient time in the
16:37:05 21 evening. And then I took it again before this
16:37:09 22 news broke.
16:37:10 23 And our goal was always to
16:37:12 24 support residents and to keep them comfortable,
16:37:17 25 to give them a natural and peaceful death. And
16:37:23 26 to know that Bethe committed these awful crimes
16:37:32 27 has been so hard.
16:37:34 28 And then going or preparing for
16:37:36 29 the Inquiry and reading the documentation of
16:37:41 30 the people that she killed, it was just so
16:37:45 31 awful.
16:37:49 32 Q. Perhaps -- is there anything

16:37:56 else, Helen, or would you like to break now?
16:38:02 A. Well, again, I want to say
16:38:04 I'm so sorry that it happened.
16:38:07 MR. HEWITT: Okay, those are my
16:38:08 questions.
16:38:08 THE COMMISSIONER: Thank you.
16:38:10 Thank you so much.
16:38:13 THE WITNESS: Thank you.
16:38:14 THE COMMISSIONER: We are going
16:38:14 to finish now, and I know that
16:38:16 it is hard, but part of it --
16:38:20 you have made me upset too --
16:38:22 part of the Public Inquiry is to
16:38:24 let people hear that.
16:38:25 THE WITNESS: And that is why
16:38:26 I'm here, because I hope it does
16:38:28 improve the system so that care,
16:38:35 you know, will be what a good
16:38:38 nurse expects for her residents.
16:38:41 THE COMMISSIONER: Yes, and that
16:38:43 is true, that is what this is
16:38:44 about, but what I am explaining
16:38:45 is that part of this is for
16:38:47 everybody who has been harmed
16:38:48 through the process, including
16:38:49 you.
16:38:50 So as hard as it is, I hope that
16:38:53 you find that there is some
16:38:55 closure to the events by being
16:38:57 able to publicly explain your
16:39:00 feelings and to assist us with
16:39:02 our fact-finding process.

16:39:03 So I wanted to just let you know
16:39:05 how much we appreciate it. We
16:39:07 know how hard it must be for
16:39:09 you. So thank you.
16:39:10 THE WITNESS: Thank you.
16:39:12 MS. HEWITT: Thank you,
16:39:13 Commissioner. So obviously,
16:39:14 there is some cross-examinations
16:39:17 that will continue on Monday.
16:39:20 Mr. Sandler has indicated that
16:39:21 perhaps we should mark Ms. Yee's
16:39:24 statement as an exhibit and I am
16:39:26 probably going to get chastised
16:39:28 by our document person as soon
16:39:29 as we leave because I probably
16:39:31 should have made anything that
16:39:32 wasn't in the exhibit -- or in
16:39:34 the affidavit an exhibit.
16:39:36 So I'm at your mercy. We could
16:39:39 make everything --
16:39:40 THE COMMISSIONER: I think all
16:39:41 the documents that were not
16:39:43 marked as exhibits, and there
16:39:44 were not that many of them, are
16:39:46 in the database and in the ORs,
16:39:49 and the only reason that there
16:39:50 is a gap and we are having to
16:39:52 deal with this is because there
16:39:55 is a gap for the public and
16:39:57 those documents are going to be
16:39:58 coming up. In my view, the
16:40:01 transcript can be followed

16:40:03 without marking those, and there
16:40:05 are very few, and it is late in
16:40:07 the day.
16:40:07 So in my view, we will leave it
16:40:09 at this stage. If anybody has
16:40:10 the view that the public is
16:40:12 either not able to follow it or
16:40:13 whatever, I will on Monday
16:40:15 morning, the first thing we'll
16:40:17 do is we'll put the documents
16:40:18 in.
16:40:19 MR. SANDLER: I respectfully
16:40:21 just want to say to you,
16:40:26 Commissioner, first of all it
16:40:27 turned out that my objection was
16:40:28 all for naught, and not that you
16:40:30 need to --
16:40:30 THE COMMISSIONER: Call it the
16:40:31 Commissioner's intuition,
16:40:32 Mr. Sandler.
16:40:34 MR. SANDLER: It turned out to
16:40:37 be much ado about not much. But
16:40:40 what I am concerned about is the
16:40:42 witness has effectively adopted
16:40:44 the balance of the statement and
16:40:47 the public has no way of seeing
16:40:49 the balance, they have only
16:40:51 heard what she has described.
16:40:52 And I am concerned about it
16:40:53 simply because I would like the
16:40:54 public, or the media if they are
16:40:56 reporting on that story, to see

16:40:57 the full report.
16:40:58 THE COMMISSIONER: The report by
16:41:02 Inspector Yee you are talking
16:41:05 about from the College?
16:41:07 MR. SANDLER: Yes.
16:41:07 THE COMMISSIONER: It was up on
16:41:08 the screen.
16:41:08 MR. SANDLER: Well, it was up on
16:41:09 the screen, but nobody had the
16:41:11 opportunity to read that on the
16:41:13 screen, it momentarily flashed,
16:41:16 that is all I'm saying.
16:41:17 THE COMMISSIONER: It does go
16:41:19 through on the website, and the
16:41:21 webcast is available to go back
16:41:22 and look at. Is that of any
16:41:24 comfort? I mean, if I watch the
16:41:26 webcast and I want to stop and
16:41:29 go back, I can go back and look.
16:41:32 MR. SANDLER: I wasn't sure that
16:41:33 the full document was projected
16:41:37 with both of its pages, but --
16:41:40 MS. HEWITT: I think --
16:41:42 MR. SANDLER: If you tell me it
16:41:43 was...
16:41:43 THE COMMISSIONER: Well, I mean,
16:41:44 that is my understanding. Part
16:41:45 of the reason of why I'm doing
16:41:47 my recordkeeping and everything
16:41:49 the way I am is I am trying to
16:41:51 position myself exactly like a
16:41:53 person in the public. And so if

16:41:57 1 I could see it and saw the whole
16:41:59 2 document, my understanding is
16:42:01 3 that so could the public. Am I
16:42:03 4 wrong on that?
16:42:04 5 And also we have the capacity
16:42:07 6 through the webcast for anyone
16:42:08 7 to go back.
16:42:10 8 MR. SANDLER: Okay, that is fine
16:42:11 9 with me.
16:42:11 10 THE COMMISSIONER: So I think
16:42:12 11 that that is fine. Your concern
16:42:15 12 is that the public should be
16:42:17 13 able to see the entire document
16:42:19 14 that was up?
16:42:19 15 MR. SANDLER: Yes, because it is
16:42:21 16 very significant what is in the
16:42:22 17 document, not merely what a
16:42:25 18 relatively small difference is.
16:42:26 19 THE COMMISSIONER: All right.
16:42:27 20 Well, I am seeing all kinds of
16:42:29 21 much more knowledgeable heads
16:42:30 22 than mine nodding that my
16:42:32 23 understanding is correct, but
16:42:33 24 what I would say is in light of
16:42:34 25 that consideration, there is not
16:42:36 26 a difficulty for us to mark the
16:42:41 27 inspection, the inspector's
16:42:42 28 notes as an exhibit at this
16:42:44 29 stage and then --
16:42:46 30 MS. HEWITT: Would it be Exhibit
16:42:48 31 "A," though? They haven't
16:42:49 32 actually been actually

16:42:51 identified by the maker.
16:42:53 THE COMMISSIONER: True, but
16:42:53 they are already produced and
16:42:55 therefore part of the exhibit,
16:42:56 and so in my view, we don't have
16:42:58 to have them identified by the
16:43:00 maker, right, because they are
16:43:01 part of another one.
16:43:02 MS. HEWITT: Right.
16:43:02 MR. SANDLER: Thank you,
16:43:04 Commissioner, that is fine.
16:43:05 THE COMMISSIONER: Yeah, so I
16:43:06 think that is not a difficulty
16:43:07 at all. So --
16:43:12 MS. HEWITT: I don't have a
16:43:13 clean copy. This is
16:43:15 Mr. Golden's.
16:43:15 MR. SANDLER: We do.
16:43:16 THE COMMISSIONER: All right.
16:43:20 So do you by chance have two
16:43:22 clean copies because I would
16:43:24 like just to make sure that I
16:43:25 have a full record up here as
16:43:27 well?
16:43:27 MR. SANDLER: Yes.
16:43:39 MS. HEWITT: Here is one, and
16:43:40 two. Thank you, Madam Clerk.
16:43:50 THE COMMISSIONER: Thank you so
16:43:51 much. So just to check, by my
16:43:55 notes, is that Exhibit 17, Madam
16:44:00 Clerk?
16:44:00 THE COURT CLERK: That is

16:44:01 correct.
16:44:01 THE COMMISSIONER: Exhibit 17
16:44:02 then is a document, a two-page
16:44:12 document beginning with the
16:44:14 words "Name of contact Helen
16:44:16 Crombez DON, date of contact
16:44:22 July 30, 2014," responded to by
16:44:24 Karen Yee, Intake Investigator.
16:44:27 And that is also in the
16:44:29 documents at document number
16:44:32 36847.
16:44:36 EXHIBIT NO. 17: Interview
16:44:36 summary by Intake Investigator
16:44:38 Karen Yee.
16:44:38 THE COURT CLERK: And
16:44:39 Commissioner, the title of the
16:44:40 exhibit should be?
16:44:41 THE COMMISSIONER: Interview
16:44:42 summary by telephone.
16:44:43 THE COURT CLERK: Thank you.
16:44:44 THE COMMISSIONER: Thank you.
16:44:45 All right. So is there anything
16:44:54 else then that needs to be done
16:44:57 before we convene for the
16:44:59 weekend?
16:45:02 MS. HEWITT: I don't see anybody
16:45:03 rushing to their feet,
16:45:05 Commissioner.
16:45:05 THE COMMISSIONER: I think
16:45:06 everybody has had a long week,
16:45:07 and I thank everyone for their
16:45:09 patience and consideration

16:45:11 throughout.
16:45:11 It has been exemplary.
16:45:14 So we will start at 9:30 on
16:45:17 Monday. Will I get an email at
16:45:19 all with some indication of the
16:45:21 order in which examinations and
16:45:23 cross-examinations will take
16:45:24 place?
16:45:24 MS. HEWITT: We can arrange
16:45:26 that. Does anyone know whether
16:45:28 they are switching times or
16:45:30 sequence? Yes, we can arrange
16:45:32 to send you that email. It
16:45:33 would be Mr. Golden would be
16:45:35 entitled to ask questions first.
16:45:36 THE COMMISSIONER: Right.
16:45:37 MS. HEWITT: And then the
16:45:38 sequence would go from there.
16:45:39 The families would be up next.
16:45:42 THE COMMISSIONER: Okay, thank
16:45:43 you.
16:45:44 All right. Then with that in
16:45:47 mind, as I am just going to
16:45:50 remind you, they are going to
16:45:51 come in to clean the courtroom,
16:45:53 so if you do have anything in
16:45:54 here, you may want to remove it.
16:45:57 But everybody can leave their
16:45:59 name tags and stuff, right?
16:46:01 Their name plates?
16:46:04 All right, thank you very much
16:46:05 all.

16:46:05

-- Adjourned at 4:46 p.m.

REPORTER'S CERTIFICATE

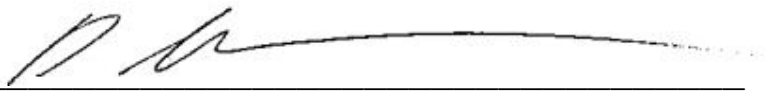
I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify;

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

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

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

Dated this 8th day of June, 2018



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