

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

1 A P P E A R A N C E S:
2
3 Elizabeth Hewitt, Esq., Commission Counsel
4 & Lara Kinkartz, Esq.,
5 & Rebecca Jones, Esq.,
6 & Megan Stephens, Esq.,
7
8 Jared B. Schwartz, Esq., AdvantAge Ontario
9
10
11 Jane Meadus, Esq., Ontario Association
12 of Residents'
13 Councils
14
15 David M. Golden, Esq., Caressant Care
16 Nursing and
17 Retirement Homes
18 Limited, Caressant
19 Care - Woodstock
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21 Mark Sandler, Esq., College of Nurses
22 & Megan Schwartzentruber, Esq.
23
24 Paul H. Scott, Esq., Jon Matheson, Pat
25 Houde, Beverly
26 Bertram
27
28 Judith Parker, Esq., Her Majesty the
29 Queen in Right of
30 Ontario
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A P P E A R A N C E S (CONT'D):

Alex Van Kralingen, Esq., Arpad Jr. Horvath,
& Katherine Chau, Esq., 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., Ontario Nurses
& Nicole Butt, Esq., Association

Lauren Binhammer, Esq., Registered Nurses'
Association of
Ontario

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

ALSO PRESENT:

Dr. Fred Mather, Ontario Long-Term
Care Clinicians

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HELEN CROMBEZ;

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09:13:29 1 -- Upon commencing at 9:32 a.m.

09:32:03 2 THE COMMISSIONER: Good morning.

09:32:04 3 MS. HEWITT: Good morning,

09:32:05 4 Commissioner.

09:32:05 5 Just before we go back to

09:32:09 6 Mrs. Crombez, could we make

09:32:10 7 Exhibit 16 subject to

09:32:12 8 redactions. All the documents

09:32:14 9 in the database have all been

09:32:15 10 redacted, but there's a couple

09:32:17 11 of things that we have to do

09:32:18 12 with the exhibit itself.

09:32:19 13 THE COMMISSIONER: Yes, no

09:32:20 14 problem. So Exhibit 16 should

09:32:23 15 now be marked as subject to

09:32:25 16 redaction, please, Madam Clerk.

09:32:28 17 THE COURT CLERK: Noted, thank

09:32:29 18 you.

09:32:33 19 HELEN CROMBEZ; Under Prior Oath.

09:32:34 20 EXAMINATION IN-CHIEF BY MS.

09:32:34 21 HEWITT (CONT'D):

09:32:37 22 Q. Good morning, Mrs. Crombez.

09:32:39 23 A. Would you please call me

09:32:42 24 Helen. And good morning, Liz.

09:32:44 25 Q. I'm fine with calling you

09:32:47 26 Helen.

09:32:47 27 Yesterday we went through some

09:32:49 28 preliminary stuff with you, and today we are

09:32:51 29 going to go through some fairly technical

09:32:53 30 things in terms of what happened at Caressant

09:32:55 31 Care regarding medication management, et

09:32:59 32 cetera, and regarding insulin.

09:33:00 1 So I'm going to take you through
09:33:02 2 a lot of the evidence this morning by reading
09:33:06 3 into the record your affidavit parts, and then
09:33:10 4 asking you questions based on the information
09:33:12 5 that you have provided to us.

09:33:14 6 So first of all, I would like to
09:33:16 7 turn, Commissioner, to Exhibit 16, the
09:33:20 8 affidavit. You know what the -- I'm not sure
09:33:27 9 what the affidavit number is.

09:33:29 10 A. I have alphabetical numbers.
09:33:32 11 Am I supposed to look at this or --

09:33:35 12 Q. No, you can turn to the hard
09:33:37 13 copy that you have. If you can turn to page
09:33:39 14 number 8, paragraph number 41. We are just
09:33:44 15 going to get it --

09:33:46 16 A. Page number 8?

09:33:50 17 Q. Down at the bottom, paragraph
09:33:52 18 41.

09:33:53 19 A. Uhm-hmm.

09:33:53 20 Q. All right, we'll just wait
09:33:55 21 until that gets up on the screen.

09:33:59 22 A. While we are waiting, I would
09:34:00 23 like to apologize. I said I was Director of
09:34:03 24 Nursing yesterday 33 years, and I would like to
09:34:05 25 correct that. It is 30, as it was in my
09:34:09 26 document.

09:34:10 27 Q. Okay, thank you for that
09:34:12 28 correction. A long time?

09:34:14 29 A. Yes, a long time.

09:34:16 30 Q. So can we move to page 8,
09:34:22 31 paragraph 41, down at the bottom. So your
09:34:30 32 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

09:35:35 1 would ask for the form to be
09:35:37 2 faxed to his office. Once the
09:35:38 3 orders were received from the
09:35:40 4 Doctor, the Med Rec was faxed to
09:35:42 5 the pharmacy and a hard copy put
09:35:45 6 in the pharmacy bag to go to the
09:35:46 7 pharmacy. The Pharmacist would
09:35:49 8 sometimes call the nurse to
09:35:50 9 clarify and vice versa."
09:35:52 10 Who was the pharmacy at
09:35:54 11 Caressant Care?

09:35:55 12 A. The pharmacy was Medical
09:35:59 13 Pharmacy.

09:35:59 14 Q. And my understanding from
09:36:00 15 your affidavit is that pharmacy was with
09:36:04 16 Caressant Care for the period that Elizabeth
09:36:07 17 Wettlaufer was there, 2007 to 2014?

09:36:10 18 A. Yes.

09:36:10 19 Q. So when a resident enters
09:36:15 20 long-term care, is their medication management
09:36:19 21 required to be taken over by the home?

09:36:21 22 A. Yes.

09:36:21 23 Q. And so this process of
09:36:23 24 Medication Reconciliation would be required and
09:36:28 25 is it fair to say it is aimed at switching the
09:36:31 26 resident's medication from wherever they were
09:36:33 27 or whichever pharmacy they were with to the
09:36:36 28 home's pharmacy?

09:36:37 29 A. That's correct.

09:36:37 30 Q. In your experience, are most
09:36:42 31 residents that enter long-term care on
09:36:45 32 medications?

09:36:46 1 A. Yes, most are.

09:36:47 2 Q. And in your experience, would

09:36:51 3 they be multiple medications?

09:36:54 4 A. I would say most residents

09:36:59 5 had multiple medications.

09:37:00 6 Q. We heard some testimony

09:37:03 7 yesterday, or Mr. Sandler indicated that some

09:37:07 8 testimony may be coming in the days to come as

09:37:10 9 to the number of medications that a nurse would

09:37:13 10 give out on any given shift, and the numbers

09:37:17 11 for each nurse or Registered Nurse or

09:37:21 12 Registered Practical Nurse is indicated to be

09:37:23 13 in the hundreds. Is that something that would

09:37:25 14 be fair to say?

09:37:26 15 A. That's correct.

09:37:27 16 Q. And that is on every single

09:37:29 17 shift?

09:37:29 18 A. That's correct.

09:37:30 19 Q. And that would only be --

09:37:32 20 A. Except night shift.

09:37:33 21 Q. Except night shift. Yeah,

09:37:37 22 we'll get into the way that medications work,

09:37:40 23 but typically, let's take day shift, the

09:37:42 24 hundreds of medications per shift, correct?

09:37:44 25 A. Correct.

09:37:45 26 Q. And then hundreds of

09:37:46 27 medications for only a portion of the residents

09:37:49 28 that they are taking care of; is that correct?

09:37:51 29 A. That's correct.

09:37:52 30 Q. And in terms of the

09:37:56 31 medications, would the doctor's orders identify

09:37:59 32 when those medications are to be given out?

09:38:01 1 A. The directions could be
09:38:08 2 specific or it could be left up to the nurse to
09:38:13 3 decide. We might get an order for BID, which
09:38:18 4 means twice a day, and the nurse could decide
09:38:23 5 based on her knowledge if it would be better
09:38:27 6 given early in the morning, say at 6:00, or
09:38:33 7 with food at breakfast time, and then the same
09:38:35 8 with the second dose, when would it be best to
09:38:37 9 give.

09:38:38 10 Q. So there is some times when
09:38:40 11 it would be -- it must be taken at breakfast?

09:38:44 12 A. Uhm-hmm.

09:38:44 13 Q. Other times, as I understand
09:38:46 14 your testimony, it will say bi-daily, but that
09:38:50 15 is at the discretion of the nurse; is that
09:38:53 16 correct?

09:38:53 17 A. Yes, what time to put it,
09:38:55 18 yes.

09:38:55 19 Q. But no one else on that shift
09:38:57 20 would be able to exceed that particular dose?

09:38:59 21 A. That's correct, without -- if
09:39:02 22 there needed to be a change to the dosage, then
09:39:05 23 the doctor should be called.

09:39:08 24 Q. But other than that, it is
09:39:09 25 twice daily and that is it?

09:39:11 26 A. That's right.

09:39:11 27 Q. And we have heard some
09:39:13 28 evidence of what is called PRN medication, and
09:39:18 29 what is that?

09:39:18 30 A. PRN stands for as needed.

09:39:24 31 Q. So that would again be up to
09:39:26 32 the discretion of the nurse?

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A. Yes.

Q. And are there limitations on that discretion in terms of how often you can exercise it?

A. There may be limitations on so many tablets per day, or, you know, up to four times a day, that kind of thing.

Q. And all of that information, where would that be contained for the nurse that is going to do any particular medication distribution in the home?

A. That would be on the doctor's order sheet.

Q. Would it also be on the Medication Administration Record?

A. Yes, then it would be transferred to the Medication Administration Record.

Q. So when a resident first comes into long-term care, that whole process needs to be done in order to get the right medications at the right time for the right resident?

A. That's correct.

Q. Okay. Now, my understanding is that in terms of the medications that may be given to residents, they could be a combination of controlled and non-controlled drugs; is that correct?

A. That's correct.

Q. And when we speak of controlled drugs, those are narcotics, for

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example?

A. Narcotics and Ativan were considered the controlled drugs.

Q. And we heard earlier testimony, is Ativan also known as Lorazepam?

A. That's correct.

Q. And what would be an example of a non-controlled drug?

A. Lasix, Tylenol, any laxative.

Q. And just for the benefit of those that aren't in the nurse's profession, what would Lasix be used for?

A. Fluid accumulation.

Q. So you are trying to get the fluid out of the resident?

A. Yes, it is usually demonstrated in the lower legs, but it can, you know, be around the heart as well.

Q. And the medications coming in could be in pill form or injectable forms of both controlled and non-controlled drugs; is that correct?

A. Correct.

Q. And one injectable form of a non-controlled drug is insulin?

A. That's correct.

Q. Now, once all of the medications are reconciled, what happens next in the admission process? So you have now got the right medications ordered with the pharmacy.

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

09:43:54 1 talk about the delivery of medications in a
09:43:55 2 moment, and for your benefit as well,
09:43:57 3 Commissioner, we are going to deal with insulin
09:43:59 4 on its own. We are just doing generalities
09:44:01 5 right now for medication management and
09:44:04 6 administration.

09:44:05 7 So we'll talk about delivery in
09:44:09 8 a moment, but once they come to the home, you
09:44:11 9 indicated that the cycle strips, for instance,
09:44:14 10 are put in the medication cart?

09:44:17 11 A. That's correct.

09:44:17 12 Q. And yesterday I believe you
09:44:19 13 testified that those carts are locked and only
09:44:23 14 registered staff have the keys?

09:44:24 15 A. That's correct.

09:44:25 16 Q. And that those carts, if they
09:44:28 17 are not being used, are locked then in the
09:44:30 18 medication rooms?

09:44:31 19 A. Yes.

09:44:32 20 Q. Now, does the same key open
09:44:34 21 both the medication cart and the medication
09:44:37 22 room?

09:44:37 23 A. No, the medication room was a
09:44:42 24 separate key and each cart had a separate key.

09:44:45 25 Q. And those, I think you said,
09:44:53 26 go right into the medication cart, the cycle
09:44:57 27 strips?

09:44:57 28 A. Yes, they do.

09:44:58 29 Q. And where in the medication
09:45:00 30 cart would those be located?

09:45:02 31 A. Well, there were probably
09:45:03 32 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 1 you know, two or three of those pouches.
09:46:54 2 Q. And per medication pass or
09:46:59 3 two or three of those pouches because they are
09:47:01 4 getting medications in the morning and at lunch
09:47:04 5 and then in the evening?

09:47:05 6 A. No, for the one pass in the
09:47:07 7 morning.

09:47:07 8 Q. And what would determine
09:47:08 9 whether they have more than one of the little
09:47:10 10 packages?

09:47:11 11 A. Just what the doctor ordered.

09:47:14 12 Q. Right. So would that be just
09:47:15 13 a volume issue as to how much you can fit in
09:47:19 14 one of those?

09:47:19 15 A. Uhm-hmm.

09:47:20 16 Q. Sorry?

09:47:20 17 A. Yes, you know, there was only
09:47:22 18 so much room in the pouch, and there was only
09:47:25 19 so much room to write or print on the pouches,
09:47:30 20 so...

09:47:30 21 Q. So the medications are
09:47:32 22 ordered. They come in and, as I said, we'll
09:47:36 23 deal with it coming in in a minute, but the
09:47:38 24 strip pills are put in a bin with the
09:47:41 25 resident's name in a medication cart that is
09:47:43 26 locked; have I got that correct?

09:47:44 27 A. That's correct.

09:47:45 28 Q. And please tell me, because
09:47:46 29 it is your profession, not mine, if I don't
09:47:49 30 have that -- if I'm not summarizing your
09:47:52 31 evidence correctly.

09:47:54 32 Now, how about narcotics or

09:47:57 1 controlled drugs. Do those come in those
09:47:59 2 little type packages?

09:48:00 3 A. No, they stayed in the carded
09:48:04 4 system, so we would have a month's supply of
09:48:07 5 those. And the card would hold 31 tablets, and
09:48:17 6 you would start with number 31 on the top
09:48:21 7 left-hand side and work your way down the
09:48:24 8 numbers until the card was empty.

09:48:26 9 Q. Let me stop you there,
09:48:28 10 because I am too old and I need visual aids, so
09:48:34 11 I'm going to take you to a document that is
09:48:36 12 actually in your exhibit, and it is tab number
09:48:39 13 GG and it is document number 16910. And we are
09:48:56 14 actually going to look at a medication error
09:48:57 15 that was attributed to Elizabeth Wettlaufer and
09:49:01 16 just see if we can talk about two things at
09:49:08 17 once, basically.

09:49:08 18 So if you are at tab GG,
09:49:11 19 document 16910, all right, first of all, can
09:49:30 20 you identify what is this document?

09:49:32 21 A. This is a Caressant Care
09:49:36 22 internal resident Incident Report.

09:49:40 23 Q. What would it be used for?

09:49:41 24 A. It was filled out when there
09:49:46 25 was an incident regarding a resident, whether
09:49:50 26 it was a medication error or a fall.

09:49:54 27 Q. And on this particular form,
09:49:57 28 at the top of the page it says date and time of
09:50:01 29 incident, March 23, 2008, 20:45, so that would
09:50:09 30 be 8:45 in the evening; am I reading that
09:50:12 31 right?

09:50:13 32 A. Actually 6:25 -- oh, up here,

09:50:15 1 sorry, yes, 8:45, right.

09:50:16 2 Q. Would that be the evening

09:50:18 3 shift?

09:50:22 4 A. Yes, it would be, uhm-hmm.

09:50:23 5 Q. And we have the next

09:50:24 6 identifier, the name of the person who

09:50:26 7 discovered incident, and the individuals are

09:50:27 8 named there?

09:50:28 9 A. Yes, they were doing the

09:50:30 10 narcotic count, I believe.

09:50:31 11 Q. And then "type of incident,"

09:50:34 12 it has a dot and "medication error." Was this

09:50:38 13 a computerized system?

09:50:42 14 A. How do you mean a

09:50:43 15 computerized system?

09:50:44 16 Q. Was it online? Did they fill

09:50:45 17 it out online and push --

09:50:47 18 A. Yes, it was part of our Point

09:50:49 19 Click Care system, yes.

09:50:50 20 Q. And down under "Description,"

09:50:53 21 "Brief description of incident":

09:50:56 22 "During narcotic count on March

09:50:59 23 23, '08 HS Tylenol #3 signed for

09:51:04 24 as given but not given."

09:51:05 25 Just for the benefit of myself

09:51:07 26 and those watching, what do the initials "HS"

09:51:12 27 stand for.

09:51:13 28 A. Bedtime.

09:51:14 29 Q. Bedtime, thank you. And

09:51:16 30 Tylenol number 3, would that be a controlled

09:51:18 31 drug?

09:51:19 32 A. Yes, it would be.

09:51:20 1 Q. And --

09:51:28 2 MR. SANDLER: Sorry, I misheard

09:51:30 3 what HS stands for, sorry.

09:51:33 4 MS. HEWITT: Bedtime.

09:51:34 5 MR. SANDLER: Bedtime, thank

09:51:35 6 you.

09:51:36 7 BY MS. HEWITT:

09:51:38 8 Q. And then down at the bottom

09:51:40 9 right-hand side, and I'm not going to go to the

09:51:42 10 top yet, but bottom right-hand side is "Please

09:51:45 11 file for Bethe." Is it your understanding that

09:51:47 12 this medication incident involved Ms.

09:51:51 13 Wettlaufer?

09:51:51 14 A. Yes, I do.

09:51:52 15 Q. Now, I said I was going to do

09:51:55 16 some education on both things at once, so if I

09:51:58 17 can have you turn to document 16911. It is in

09:52:03 18 that same tab, Commissioner, just the next

09:52:06 19 document.

09:52:12 20 A. I don't have the next

09:52:13 21 document.

09:52:14 22 THE COMMISSIONER: Behind the

09:52:15 23 blue --

09:52:16 24 BY MS. HEWITT:

09:52:16 25 Q. There should be a blue --

09:52:17 26 A. Oh, a blue divider sheet?

09:52:19 27 Sorry, yes, yes, this is it.

09:52:20 28 Q. Now, you were -- before I

09:52:24 29 took you to that first document, you were

09:52:25 30 talking about a narcotic card and you started

09:52:27 31 to talk about number 31 down, so this document,

09:52:35 32 this copy of something that we are looking at,

09:52:36 1 what is this?

09:52:38 2 A. This is a medication card for

09:52:42 3 Tylenol number 3.

09:52:45 4 Q. And is this what you were

09:52:46 5 talking about, the narcotic card that would be

09:52:48 6 delivered for each resident?

09:52:50 7 A. That's right, if it were

09:52:51 8 ordered, this is how it would come.

09:52:53 9 Q. All right.

09:52:55 10 A. If it were in pill form.

09:52:57 11 Q. Right, if it was injectable,

09:52:59 12 it would be a different form. But the narcotic

09:53:02 13 card that you are talking about, this would

09:53:05 14 identify the resident at the top, does it?

09:53:09 15 A. That's correct.

09:53:10 16 Q. And what other information at

09:53:12 17 the top does this particular copy of this card

09:53:16 18 give us?

09:53:17 19 A. Well, it gives us the

09:53:20 20 pharmacy supplier, the treatment number, or

09:53:28 21 prescription number, rather, that this

09:53:30 22 medication belongs at Caressant Care Nursing

09:53:38 23 Home, on south, I believe.

09:53:41 24 Q. Okay.

09:53:41 25 A. And the directions are there,

09:53:44 26 "1 to 2 tablets by mouth 4 times daily," and

09:53:48 27 then it gives the generic name and then it

09:53:53 28 gives a description of what the pill actually

09:53:55 29 looks like and then the doctor who ordered it.

09:53:58 30 Q. And by the description, you

09:54:02 31 are talking about "Tylenol No. 3 round white

09:54:08 32 tec RPH"?

09:54:09 1 A. Yes.

09:54:10 2 Q. What does "RPH" mean?

09:54:13 3 A. Sorry?

09:54:14 4 Q. The description, number 3, is

09:54:16 5 that RND, is that round?

09:54:18 6 A. Yes, Tylenol number 3 round,

09:54:20 7 it is a white round tablet. I am not sure what

09:54:23 8 the "Tec RPH," that might be some printing on

09:54:28 9 the other side of the tablet, I'm not sure.

09:54:30 10 Q. All right, but the nurse

09:54:32 11 should be able to determine am I giving a white

09:54:34 12 round pill or am I giving an oval pink pill by

09:54:38 13 that description?

09:54:38 14 A. That's correct.

09:54:39 15 Q. Now, can you tell by looking

09:54:41 16 at this card -- we notice that the medication

09:54:44 17 incident was that a drug wasn't given. Can you

09:54:46 18 tell by looking at this card if that was the

09:54:48 19 case?

09:54:49 20 A. Yes, there appears to be a

09:54:52 21 round white tablet in pocket number 1.

09:54:57 22 Q. Now, you started this morning

09:55:00 23 when you were talking about the card, you said

09:55:01 24 you start at 31, and so I notice on this card

09:55:04 25 at the very top, it is actually nice printing

09:55:10 26 that I can see, it says "start"; is that what

09:55:13 27 you were talking about?

09:55:14 28 A. That's correct.

09:55:14 29 Q. So the nurse starts at pill

09:55:18 30 number 31 and goes down to pill number 1?

09:55:21 31 A. That's correct.

09:55:21 32 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 1 ago to document medication.

09:58:28 2 Q. Oh.

09:58:29 3 A. If there were two tablets, it
09:58:32 4 would have two little lines and two little
09:58:34 5 dots.

09:58:34 6 Q. Are you still using that
09:58:35 7 system today? This is 2000 -- sorry, this was
09:58:41 8 quite some time ago, 2008. Is that still the
09:58:45 9 system, to the best of your knowledge?

09:58:46 10 A. As far as I know.

09:58:47 11 Q. Okay. And then if we go over
09:58:49 12 to "amount wasted," what would that -- there is
09:58:52 13 nothing here, but what would that generally
09:58:54 14 signify?

09:58:54 15 A. Well, if you dropped it on
09:58:58 16 the floor, for instance, or if, you know, the
09:59:01 17 resident didn't want it for some reason.

09:59:08 18 Q. And then the final column is
09:59:14 19 "quantity/balance," and that is where it says
09:59:18 20 there is 30 left; is that correct?

09:59:19 21 A. Yeah, that number should
09:59:21 22 match, you know, what isn't circled on your
09:59:25 23 left-hand column.

09:59:26 24 Q. All right. I won't take you
09:59:28 25 back, so we don't flip back and forth, but
09:59:33 26 document number 16911, the pill that you
09:59:37 27 indicated is found in blister number 1. So can
09:59:42 28 you tell us if by looking at this Individual
09:59:45 29 Narcotic Medication Record you can identify who
09:59:49 30 signed the pill as being given but then others
09:59:55 31 discovered it was still in the pack?

09:59:56 32 A. It was Bethe Wettlaufer that

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1 failed to give this medication.
2 Q. And just for our benefit, can
3 you tell us how you determined that?
4 A. That is her signature.
5 Q. And is that at the very
6 bottom?
7 A. That is at the very bottom,
8 yes.
9 Q. So the bottom, we know from
10 your testimony that she should have been taking
11 out of blister 1 that pill and she would only
12 sign this document if it was given; is that
13 correct?
14 A. That's correct.
15 Q. And so --
16 A. She wasn't following proper
17 process.
18 Q. All right, and that was
19 brought to your attention, I assume?
20 A. That's correct.
21 Q. All right. I do want to take
22 you, just to round out this particular incident
23 so we won't have to go back potentially later,
24 if I can take you back in that same tab to the
25 first document and that is document 16910.
26 Now, whose handwriting appears
27 on the right-hand side of that document?
28 A. That is my handwriting.
29 Q. And could you read it for us?
30 A. I determined that it was
31 Bethe's mistake, so I had written here:
32 "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.

1 Q. And is that philosophy
2 accepted within the profession, from your
3 experience?

4 A. Yes, it is.

5 Q. And that type of a situation
6 where you attempt to not discipline for med
7 errors, is that a positive, a negative, or
8 neutral change, from your perspective?

9 A. I thought it was a positive
10 change. I wanted nurses to report so that if
11 it was something serious, it could be
12 corrected.

13 Q. And what would happen if a
14 nurse didn't come forward to report a serious
15 error she had made, or he, and realized but
16 didn't come forward? What is the potential
17 ramifications of that?

18 A. Well, I could use an example
19 from a hospital setting that I was aware of.

20 Q. As long as -- we are fine
21 with any examples, as long as no patients'
22 names are used.

23 A. I don't know any of the
24 people's names, but it was regarding insulin as
25 well and the nurse gave 1,000 units in error
26 and realized it almost immediately. There was
27 an insulin specialist in the hospital. She
28 quickly notified her superior and this doctor
29 was brought to the floor, and the patient did
30 not -- the patient didn't die, because of her
31 action.

32 Q. All right.

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A. And she was not disciplined.

Q. Thank you. So we have looked at the narcotic card and a medication incident all together, so we can accomplish a couple of things at once.

But I want to continue with our discussion on medication management, so I want to go back to your affidavit and, in particular, paragraph 42. And just quickly, you indicate:

"Reordering of medication is done automatically through the cycle system. We have a weekly supply of medications for each resident and they come at a scheduled time and a scheduled day for each floor. If there are changes to a resident's medication, that order is faxed to pharmacy at the time of change."

And then paragraph 44:

"When received, medications are scanned in and checked by the night nurse. The medications come two days early so that the staff have two nights to check the medications and if there's any discrepancies those are hopefully corrected before the cycle goes into effect."

So are they delivered to the

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1 night nurse or are they delivered on a
2 different shift?
3 A. They are delivered on the
4 evening shift around suppertime, which was 5
5 o'clock.
6 Q. And when they are delivered,
7 in general how were they packaged? How do they
8 come into the home?
9 A. If it was the cycle-fill that
10 they were receiving, it would be in a tote.
11 Q. And that is all those little
12 strip medications?
13 A. Yes.
14 Q. And narcotics?
15 A. They would be packaged
16 separately.
17 Q. Would they come in the same
18 shipment?
19 A. At the same time, but in a
20 different bag.
21 Q. All right.
22 A. I believe.
23 Q. Now, you indicate that the
24 cycle strips -- sorry, you indicate that they
25 come in and they are accepted on the afternoon
26 shift, and then generally speaking it is the
27 night shift that enters them and reconciles
28 them; is that correct?
29 A. That's correct.
30 Q. So until the night nurse gets
31 to those medications that are in the tote or
32 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

10:09:13 1 into the home and I think you indicated that
10:09:16 2 they were to be put right away into the
10:09:18 3 medication cart; is that correct?

10:09:21 4 A. That's correct. It might not
10:09:22 5 be in the right cart, but the nurse who took
10:09:25 6 the medications would just put them in her cart
10:09:27 7 and then look at that, because they were busy
10:09:31 8 giving their supper medications and then they
10:09:34 9 would, you know, distribute them when that pass
10:09:37 10 was over.

10:09:39 11 Q. Okay. And so they would, as
10:09:43 12 narcotics, always be locked up upon receipt?

10:09:47 13 A. They were supposed to be,
10:09:48 14 yes.

10:09:49 15 Q. And then when that particular
10:09:53 16 afternoon nurse or evening nurse and/or night
10:09:56 17 nurse reconciled the narcotics, I think you
10:09:58 18 indicated there was a separate step and they
10:10:00 19 would have to fax back to the pharmacy what
10:10:04 20 they had received; is that correct?

10:10:06 21 A. Fax back or it was a sheet
10:10:09 22 that the pharmacy driver took back.

10:10:13 23 Q. If they were able to do it
10:10:14 24 right then? Or did they do it right then, at
10:10:18 25 least reconcile what they received?

10:10:19 26 A. I think they did it right
10:10:20 27 then to make sure -- the pharmacy wanted to
10:10:25 28 know that we had received the medications, that
10:10:28 29 it hadn't been diverted en route.

10:10:29 30 Q. Thank you. So when the
10:10:40 31 nurses are giving out their medications, what
10:10:44 32 is that called?

10:10:44 1 A. Administration.

10:10:46 2 Q. And we have heard the term or

10:10:50 3 the term is in our Overview Report of

10:10:54 4 "medication pass"; what is that?

10:10:55 5 A. That is considered the

10:11:01 6 administration of, say, the 8 o'clock

10:11:02 7 medications to the residents.

10:11:05 8 Q. So when they say that a nurse

10:11:07 9 does a "medication pass," is that where she is

10:11:09 10 delivering all of those 8 o'clock medications?

10:11:12 11 A. The medications, that's

10:11:14 12 correct.

10:11:14 13 Q. And typically, in a day, or

10:11:21 14 in a shift, I should say, on the day shift how

10:11:24 15 many medication passes would be done?

10:11:26 16 A. Well, there would be the 8

10:11:29 17 o'clock med pass.

10:11:32 18 Q. Is that 8 o'clock in the

10:11:33 19 morning?

10:11:33 20 A. 8 o'clock in the morning.

10:11:35 21 Q. Uhm-hmm.

10:11:36 22 A. There would be a 10 o'clock

10:11:37 23 medication pass, a 12 o'clock medication pass.

10:11:49 24 There might be a few medications at 2 o'clock.

10:11:55 25 And that would be it for the day shift.

10:11:57 26 Q. Okay.

10:11:58 27 A. And there might be some

10:11:59 28 things given at, you know, 7:30 or 8:30,

10:12:07 29 depending on what the medication was.

10:12:10 30 Q. And are any of these passes

10:12:14 31 more intense than others, involve more

10:12:16 32 medications to be given out than others?

1 A. The most intensive pass was
2 the morning pass. The daily medications were
3 usually given with breakfast.

4 Q. And you indicate in your
5 affidavit at paragraph 48:

6 "When nurses would give
7 medication, they would consider
8 a number of 'rights' such as
9 right dosage, right time, right
10 route, right medication, right
11 resident, right to refuse, right
12 documentation, right effect."

13 So right doses and right time I
14 think is fairly clear, but what do you mean by
15 "right route"?

16 A. If it were -- if it was to be
17 given orally, for instance, or subcutaneously
18 or intramuscularly, or eye drops would be right
19 eye or left eye.

20 Q. Okay, and "right to refuse,"
21 what does that mean?

22 A. The resident has the right to
23 refuse, you know, the treatment and medications
24 was considered part of that.

25 Q. And if --

26 A. But we didn't give up easily.
27 We tried, you know, two or three times.

28 Q. To convince the resident, is
29 that what you mean?

30 A. To give the resident their
31 medications, gentle encouragement, you know, we
32 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

1 at 8 o'clock, most were in the dining room and
2 they did have a seating plan, you know, to help
3 with identification.

4 Q. Were residents required to
5 sit or stay seated in the dining room until
6 they got their medication or were they free to
7 wander?

8 A. No, they were free to go, and
9 if they were someone that liked to leave early,
10 the nurse would try and give -- the nurse would
11 get to know that and try and give their
12 medication before they left the dining room.

13 Q. So all of those medications,
14 however, would still have to be delivered.
15 They would have to find at some point in time
16 around that particular time every one of those
17 32 residents, if all 32 were getting
18 medications?

19 A. That's correct.

20 Q. And while they are doing
21 that, while they are doing their medication
22 pass, are they free from interruption? Is
23 somebody else responding to any issues?

24 A. No, they had interruptions.
25 They might get a phone call. They might
26 respond to a resident who is falling or choking
27 or a family member might come up to them and
28 say, I would like to take my mom out for the
29 day, that kind of thing.

30 Q. And if something like that
31 happened, speaking from experience, family
32 members can be a little pushy, but if something

10:18:46 1 like that happened, would the nurse generally
10:18:48 2 respond to what the family member wanted?

10:18:51 3 A. It depended on what the -- if
10:18:55 4 it was the family member, she would maybe
10:18:58 5 direct the family member to the ward clerk to
10:19:01 6 assist. But if, you know, she needed to take
10:19:06 7 medication with her, then the nurse would have
10:19:09 8 to stop what she was doing and help with that,
10:19:14 9 or ask her if she minded waiting, you know, 15
10:19:18 10 minutes, that kind of thing.

10:19:20 11 Q. All right. So we have talked
10:19:22 12 about the ordering, the initial reconciliation
10:19:27 13 of drugs when a resident comes into the home,
10:19:31 14 and we have talked about delivery, storage in
10:19:33 15 the medication cart, medication passes.

10:19:36 16 And I just want to talk to you
10:19:39 17 then about the end of the day, after all the
10:19:43 18 passes are done. At paragraph 49 of your
10:19:48 19 affidavit it talks about:

10:19:53 20 "Nursing staff complete the
10:19:54 21 controlled substance count every
10:19:59 22 shift. They are to remove the
10:20:00 23 narcotics from the locked bin in
10:20:02 24 the lowest drawer of the
10:20:03 25 medication cart and put it in a
10:20:05 26 cardboard box and then they are
10:20:07 27 to go to a counter or a table
10:20:10 28 and both nurses are to look at
10:20:11 29 each resident's narcotic card,
10:20:13 30 the narcotic count sheet [...]"

10:20:17 31 Is that what we referred to
10:20:18 32 later where it goes 31 down to 1?

10:20:22 1 A. That's correct.

10:20:24 2 Q. "[...] and both nurses are to

10:20:26 3 watch what the recording nurse

10:20:27 4 writes down to make sure

10:20:28 5 everything is accurate."

10:20:30 6 So as I understand your evidence

10:20:31 7 there, these counts are done at every shift

10:20:33 8 change?

10:20:33 9 A. That's correct.

10:20:34 10 Q. And if we look at Caressant

10:20:40 11 Care, can you just remind the Commissioner as

10:20:42 12 to what those shifts were?

10:20:47 13 A. The day shift was normally

10:20:48 14 7:00 to 3:00, but we, you know, did have 6:30

10:20:53 15 to 2:30 at times.

10:20:56 16 Q. Just generally speaking, 7:00

10:20:57 17 to 3:00 days.

10:21:01 18 A. 7:00 to 3:00, 3:00 to 11:00

10:21:04 19 and 11:00 to 7:00.

10:21:05 20 Q. So 3:00 to 11:00 would be

10:21:07 21 what would be called evening shift in the

10:21:08 22 record here?

10:21:09 23 A. That's correct.

10:21:09 24 Q. And 11:00 to 7:00 the night

10:21:12 25 shift?

10:21:12 26 A. That's correct.

10:21:13 27 Q. Are the narcotic counts only

10:21:16 28 to be done by registered staff?

10:21:18 29 A. That's correct.

10:21:19 30 Q. And is it only the registered

10:21:24 31 staff coming on and the registered staff coming

10:21:27 32 off that are supposed to be doing it?

1 A. Yes, and then the narcotic
2 keys are to be handed over right after the
3 narcotic count.

4 Q. And what do you mean by
5 "narcotic keys"?

6 A. Sorry, "medication keys"
7 would be a better term. Each -- we had three
8 -- we had four nurses in Section B, that, you
9 know, changed over years, but when I left we
10 had four nurses, the Charge Nurse and three
11 RPNs, and each nurse would have a set of keys.

12 So when they left, they would
13 hand their key to their on-coming nurse and the
14 night nurse would keep all sets of keys.

15 Q. So when you are saying that
16 when you left, that would be 2017?

17 A. Yes.

18 Q. Okay. And when you say
19 Charge Nurse plus three RPNs, are you talking
20 about on the day shift?

21 A. On the day shift, yes. We
22 had the highest complement of staff on the day
23 shift.

24 Q. In Section B?

25 A. In Section B.

26 Q. Okay, we'll get to the
27 staffing in a moment, but the narcotic drawer
28 within the medication bin, was that locked or
29 unlocked?

30 A. It was supposed to be locked
31 at all times, the bin itself, not the drawer,
32 just the bin itself.

1 Q. So if I open -- I can open
2 the drawer, once the medication cart is
3 unlocked; is that correct?

4 A. That's correct.

5 Q. And then when I open the
6 drawer, then what do I see?

7 A. You would see some bottles of
8 laxative to the left, and then a bin about
9 eight inches wide by ten, twelve inches deep.

10 Q. And is that affixed to the
11 cart or can I just go and take it out and be on
12 my way?

13 A. I don't know. I believe it
14 was fixed, but I never tried to pull it out.

15 Q. Okay. That is probably a
16 good thing. And that bin, I think you said,
17 was locked?

18 A. Yes.

19 Q. And is that lock a separate
20 key from the unlocking of the medication cart?

21 A. Yes, it is a little key.

22 Q. And so is it fair to say then
23 in respect of narcotics, if I'm a nurse and I
24 am coming on shift, I get the keys; if I want
25 to get a narcotic and the medication cart is in
26 the medication room, I have got a key to the
27 medication room?

28 A. Right.

29 Q. A separate key to the
30 medication cart?

31 A. Correct.

32 Q. And a separate key to the

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10:25:31
10:25:35
10:25:37
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10:25:50

1 narcotic bin once I open that drawer?
2 A. That's correct.
3 Q. And those keys, I think you
4 indicated, are turned over from the off-going
5 nurse to the on-coming nurse?
6 A. Right after narcotic count.
7 Q. Now, another thing that was
8 indicated in prior testimony is at night the
9 Charge Nurse is in charge of the building; is
10 that correct?
11 A. That is correct.
12 Q. So would the Charge Nurse
13 have additional keys on her or him for the
14 building at all?
15 A. For the building?
16 Q. Yes.
17 A. Not that I am aware, no.
18 Q. Okay. So the keys that they
19 were in control of are related to the
20 medication?
21 A. That's correct. If they had
22 to lock a door, it was with an Allen key that
23 was kept around the door somewhere in a hidden
24 spot.
25 Q. Okay, and we won't broadcast
26 to the world where those are kept.
27 Now, I just want to try to again
28 do a little bit of education, do a couple of
29 things at once. So let's just talk about
30 narcotics. Have there been narcotics that have
31 gone missing in the home while you were the
32 Director of Nursing?

1 A. Would you repeat that
2 question, please?

3 Q. Yes. Did you have any
4 narcotics in the home go missing during the
5 period that you were Director of Nursing?

6 A. Yes, I did.

7 Q. All right. And what is the
8 process if a narcotic is found missing?

9 A. Well, the nurse would try and
10 find it, or the nurses, because it usually was
11 determined at narcotic count that something was
12 missing, so they would, you know, check their
13 bins and see if the pill had, you know, fallen
14 out inadvertently.

15 And then if it couldn't be
16 found, they were to let a supervisor know.

17 Q. And what would the supervisor
18 do?

19 A. We would -- if it was a major
20 amount, we would call the police.

21 Q. So were they not reported
22 with respect to any missing narcotics or only
23 when there was a certain amount?

24 A. Well, if the narcotic
25 couldn't be found, I believe we reported it.

26 Q. All right. And when you said
27 the staff should let a supervisor know, what is
28 the process? Who would be told? What
29 positions would supervisors be?

30 A. We had people on call. If I
31 weren't in the building, then there were people
32 on call and they would call them after-hours.

1 Q. All right. So I want to take
2 you to an example of that, so we can see what
3 the process is. If I can take you to document
4 00643, tab MM in your affidavit there.

5 And we heard a little bit about
6 these documents yesterday. Are you there,
7 Helen?

8 A. Not right yet.

9 Q. Okay.

10 A. MM, did you say?

11 Q. Yes. Towards the back.
12 Almost at the back.

13 A. Yeah, I have got it here.

14 Q. Now, this is a Critical
15 Incident Report that appears to have been
16 submitted on March 15, 2013; am I right on
17 reading that date?

18 A. That's correct.

19 Q. And the critical incident
20 date and time, March 14, 2013, 23:30?

21 A. Correct.

22 Q. That would be the evening
23 shift; is that correct?

24 A. Yes.

25 Q. And then it has medication --
26 or "location, please specify," "medication room
27 in Section B"?

28 A. Yes.

29 Q. And in respect of the
30 description of the incident it states:

31 "During narcotic count by two
32 RNs at shift change between

10:29:25 1 evening shift and night shift it
10:29:27 2 was noted that 1 capsule of
10:29:30 3 Kadian SR 10 mg. was missing.
10:29:33 4 The narcotic count between day
10:29:35 5 and evening shift earlier in the
10:29:37 6 day was correct. It is possible
10:29:39 7 that resident may have received
10:29:41 8 a double dose as B. Wettlaufer,
10:29:44 9 RN reported that bin was
10:29:47 10 searched and capsule could not
10:29:48 11 be found."

10:29:53 12 So that, I think you were just
10:29:55 13 saying the first thing they do is see if they
10:29:58 14 can find that capsule?

10:29:58 15 A. That's correct.

10:29:59 16 Q. And then they couldn't find
10:30:03 17 it, and it was reported and a Critical Incident
10:30:05 18 Report is made out?

10:30:06 19 A. That's correct.

10:30:07 20 Q. All right. And if we go to
10:30:13 21 page number 2 of that document under "Actions
10:30:22 22 taken" it states:

10:30:26 23 "B. Wettlaufer, RN notified the
10:30:27 24 manager on call at 00:36, which
10:30:31 25 was myself, H. Crombez. RN
10:30:35 26 stated that there was a delay in
10:30:36 27 reporting as they searched the
10:30:37 28 lower drawer/bin for the capsule
10:30:40 29 but could not find it. H.
10:30:43 30 Crombez asked that Police
10:30:45 31 Department be notified and
10:30:46 32 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 1 A. If it was a nursing issue,
10:32:32 2 then Brenda liked me to talk, and then she
10:32:37 3 would take the notes.

10:32:38 4 Q. Okay. And can you just read
10:32:49 5 -- I just want to make sure that -- if you can
10:32:53 6 just read the part that says "At supper [...]"
10:32:59 7 and go down to "giving earlier"?

10:33:09 8 A. "At supper she will complain
10:33:11 9 of a headache, will give at 6:15
10:33:14 10 will give along with Tylenol. I
10:33:16 11 think I did that and didn't sign
10:33:18 12 off. Bethe said I did 3 things
10:33:22 13 wrong.

10:33:25 14 1, not signing MAR.

10:33:28 15 2, [not signing narcotic sheet].

10:33:32 16 3, giving earlier."

10:33:36 17 Q. Does she say actually "sheet"
10:33:38 18 on your copy, or just -- you said "not signing
10:33:43 19 narcotic sheet." Does it say "sheet"?

10:33:47 20 A. No, it doesn't, but that is
10:33:49 21 what the "Nar" means.

10:33:52 22 Q. That is what you assume. So
10:33:54 23 it appears from this document that Elizabeth
10:33:56 24 Wettlaufer was forthcoming in what she had done
10:33:58 25 wrong with that particular situation?

10:34:00 26 A. Yes.

10:34:00 27 Q. Now, in general, how did you
10:34:02 28 find Elizabeth Wettlaufer's demeanour when you
10:34:06 29 were investigating these types of incidents or
10:34:14 30 disciplining her?

10:34:15 31 A. She was usually open and
10:34:16 32 frank, would admit her mistake.

10:34:38 1 Q. And did she ever blame anyone
10:34:41 2 else for the mistakes, in your opinion?

10:34:43 3 A. No, she took ownership of her
10:34:48 4 mistake.

10:34:48 5 Q. And if I can just finally
10:34:53 6 take you to document 16813, and can you tell us
10:35:07 7 what this document is?

10:35:08 8 A. This is a Disciplinary Action
10:35:16 9 Form.

10:35:16 10 Q. And is this -- what was this
10:35:20 11 discipline for?

10:35:21 12 A. This was for the narcotic
10:35:24 13 that she couldn't account for on her shift.

10:35:28 14 Q. All right, and was that one
10:35:31 15 narcotic, one pill?

10:35:32 16 A. Yes, I believe so.

10:35:35 17 Q. And the discipline that you
10:35:37 18 gave her?

10:35:42 19 A. "A one-day suspension with
10:35:44 20 notice that continued poor work
10:35:47 21 performance related to
10:35:48 22 medication issues or resident
10:35:51 23 care issues will result in
10:35:52 24 disciplinary action up to and
10:35:54 25 including termination."

10:35:59 26 Q. Now, in the bottom left-hand
10:36:02 27 corner you signed as the signature of the
10:36:03 28 immediate supervisor; is that correct?

10:36:05 29 A. That's correct.

10:36:05 30 Q. And then Ms. Van Quaethem as
10:36:07 31 the manager?

10:36:08 32 A. That's correct.

1 Q. Now, over on the right-hand
2 side, there is a signature line for originally
3 a union rep and this has been crossed out and
4 it says "witness." So what was -- your nurses
5 were unionized; correct?

6 A. That's correct.

7 Q. And would they have a
8 representative in the home?

9 A. We did have at times. Karen
10 Routledge was a representative for quite
11 awhile, and then Mina Giraldi was, but then
12 there was no one else willing to take that role
13 on. So we just called a fellow RN to act as a
14 witness for the person being disciplined.

15 Q. And they would identify that
16 they were aware of the discipline that was
17 provided?

18 A. That's correct.

19 Q. Now, in terms of what Ms.
20 Wettlaufer would be given, would she be given a
21 copy of the discipline form?

22 A. That's correct.

23 Q. And if an ONA representative
24 was available, would they have access to a
25 copy?

26 A. If an ONA representative was
27 available, yes, certainly.

28 Q. And if it was a witness,
29 would the witness be given a copy?

30 A. I believe we did, yes.

31 Q. Okay. Now, in the bottom
32 left-hand corner, whose handwriting is that on

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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

1 00643. And if you can go to the third page,
2 under "Analysis and follow-up," it states:
3 "Memo to all registered staff
4 that starting immediately they
5 are to initial the bubble of
6 each medication that they pop
7 out of medication card. This
8 step is in addition to their
9 regular charting, recording and
10 counting of narcotics and
11 controlled substances. Incident
12 is being investigated and staff
13 are being interviewed.
14 What long-term actions are
15 planned to correct this
16 situation and prevent
17 recurrence?
18 Ongoing education regarding
19 medication administration,
20 following protocols for
21 narcotics and prompt reporting
22 of discrepancies."

23 So is that additional steps that
24 you took?

25 A. Yes.

26 Q. And just to clear up, when
27 you say they are to initial the bubble of each
28 medication that they pop out, what do you mean
29 by that?

30 A. Well, on that narcotic card
31 that we saw, some nurses, you know, would
32 automatically just initial it and circle it,

10:40:54 1 you know, that that was the one they took, but
10:40:56 2 others, you know, thought it was duplicate
10:41:01 3 documentation, if you will, taking more time,
10:41:07 4 and I, after this incident, you know, I told
10:41:09 5 them that this needed to happen.

10:41:11 6 Q. So this is actually having to
10:41:14 7 sign on the card that has the actual pills in
10:41:17 8 it; is that --

10:41:17 9 A. That's correct.

10:41:18 10 Q. So they had to do that, but
10:41:19 11 they also had to fill out that other sheet we
10:41:21 12 talked about?

10:41:23 13 A. Yes, as well as the
10:41:25 14 Medication Administration Record.

10:41:28 15 Q. So that they had given it?

10:41:30 16 A. Uhm-hmm.

10:41:31 17 Q. Okay. So let me just --

10:41:37 18 A. And if it was a PRN, they had
10:41:39 19 to put it in the Progress Notes, so there was a
10:41:42 20 lot of work involved around a PRN narcotic.

10:41:46 21 Q. So PRN narcotic, they would
10:41:48 22 have to sign the actual card that contains the
10:41:50 23 pill; correct?

10:41:51 24 A. Uhm-hmm.

10:41:51 25 Q. You have to say yes or no.

10:41:53 26 A. Yes.

10:41:54 27 Q. They would have to sign that
10:41:55 28 narcotic sheet that goes from 31 to 1; is that
10:41:58 29 correct?

10:41:58 30 A. Yes.

10:41:59 31 Q. But that is not the
10:42:00 32 Medication Administration Record; is that what

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10:43:09

1 you just said?
2 A. That's correct.
3 Q. So they would have to sign
4 off on the Medication Administration Record
5 that it had been given?
6 A. That's correct.
7 Q. And then you said if it was a
8 PRN, that they would have to note that in the
9 Progress Notes for the resident?
10 A. That's correct.
11 Q. So four sets of documenting
12 what has been done with that one narcotic pill?
13 A. That's right. And if they
14 were a really good nurse, they would go back
15 and find out what the effect was and chart that
16 as well.
17 Q. A really good nurse or a
18 really good nurse who had time?
19 A. Sorry?
20 Q. So did you expect that of all
21 your nurses?
22 A. Yes, I expected them to know
23 what the pain level was and go back and make
24 sure that it had been effective.
25 Q. Would you review Progress
26 Notes made by your nurses?
27 A. I tried to, yes.
28 Q. And would you point out
29 things such as that to them?
30 A. Yes.
31 Q. Now, we'll go back to
32 medication management. And sorry,

1 Commissioner, for flipping back and forth, but
2 I just wanted to give some actual examples of
3 these types of things that we are talking
4 about?

5 THE COMMISSIONER: That is very
6 helpful, thank you.

7 BY MS. HEWITT:

8 Q. If we can go back to
9 medication management and paragraph 50 of your
10 affidavit, I want to talk a bit about
11 destruction of drugs that are in the home.

12 So we'll talk first about
13 non-controlled drug substances. Paragraph 50
14 of your affidavit states:

15 "In terms of the destruction of
16 non-controlled drug substances,
17 each medication room has their
18 own non-controlled drug
19 destruction box. In terms of
20 discarding the empty medication
21 strip packages [...]"

22 And actually I'm going to skip
23 that, Commissioner, because that just talks
24 about what you do with the -- once you give the
25 pills what you do with the plastic strips;
26 correct?

27 A. Yes.

28 Q. And what your affidavit
29 there says is that you do things to make sure
30 that the resident's name has been taken off and
31 then --

32 A. We tried to protect the

1 resident's privacy.

2 Q. But that is not actually
3 medication, so we'll go down to paragraph 52:
4 "Every month, the pharmacist
5 consultant comes in and would
6 ask the charge nurse to open the
7 medication room. The nurse
8 would pull out the
9 non-controlled destruction box,
10 inform the Pharmacy Consultant
11 who had died or transferred,
12 changes in direction for a
13 resident or whatever question
14 might come to mind."

15 And it is not fairly clear, but
16 when -- under what circumstances would some
17 non-controlled medications have to be put in
18 that destruction box?

19 A. If a resident died, their
20 non-controlled medications would be put in
21 there. Most long-term care facilities didn't
22 want to have our medication sent with the
23 resident, just the MAR, so we would put, if
24 they were transferred, put anything that was
25 left in the box.

26 There might be a change in
27 direction for a resident, so say, for instance,
28 Lasix 40 was changed to Lasix 20 -- that might
29 not be a good example, but there would be two
30 tablets of Lasix 20 there perhaps, so you would
31 take out one 20, tape up the strip pack and put
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

1 during the month, and you go on to say:

2 "The medications would be put in
3 a double garbage bag and
4 destroyed. They are denatured
5 at the time of destruction by
6 running water into the bag and
7 covering with liquid antacid,
8 liquid laxative or cough syrup.
9 The denatured medications are
10 then packaged up and taken to a
11 storage area right away. The
12 storage area," at Caressant
13 Care, I should say, "is in the
14 basement in the medication room.
15 All nurses that are on duty have
16 access to that room."

17 So just clarify a bit this
18 process of denaturing, what does it do to the
19 non-controlled drugs?

20 A. Well, the pills come apart
21 and over time that bag becomes like a solid
22 mass.

23 Q. You mean when they come
24 apart, they get crushed or broken --

25 A. They get dissolved in the
26 liquid.

27 Q. And that is done with the
28 consultant pharmacist?

29 A. That's right. And I would
30 take that bag -- when she was done, she would
31 bring it to me and I would take that bag
32 downstairs right away.

1 Q. And then it goes on in
2 paragraph 53 to say:

3 "Once the box in the basement
4 was three-quarters full [...]"

5 So this would be done in each
6 medication room?

7 A. Yes.

8 Q. So there is a non-controlled
9 drug destruction box in each medication room?

10 A. That's correct.

11 Q. So the same process?

12 A. Yes.

13 Q. All of them taken to the same
14 area in the basement?

15 A. That's correct.

16 Q. Okay and then you go on to
17 state that:

18 "Once the box in the basement
19 was three-quarters full,
20 maintenance would take the full
21 box to their storage area in the
22 lower level. There was limited
23 access to this storage room."

24 And then you go on to talk about
25 how that box and the sharps containers would be
26 collected by the nursing staff.

27 Now, what is a sharps container?

28 A. A sharps container is where
29 we would put the needles that were used during
30 medication administration. And some nurses
31 would also put the insulin vials in there as it
32 was a little glass container.

1 Q. And when you say "vials,"
2 because we are going to get to insulin
3 momentarily, but at one point in time, as I
4 understood your evidence in the affidavit, at
5 one point in time there may have been vials and
6 needles, but now it is pen and cartridge?

7 A. That's correct.

8 Q. But when you just indicated
9 vial, would you also mean cartridge?

10 A. That's correct.

11 Q. All right. So some -- and
12 we'll get to insulin, Commissioner, but some
13 cartridges of insulin would end up in the
14 sharps container?

15 A. Yes, I believe so.

16 Q. All right. Now, once in the
17 sharps container, am I or is any other person
18 able to open the container and get that
19 cartridge out?

20 A. Not easily. I mean, you
21 could cut the container open and then put
22 everything else in a new container.

23 Q. But other than going to the
24 steps of having to cut the sharps container
25 open, is there any other mechanism to open it
26 that is at the home?

27 A. No. It was -- it had, like,
28 little teeth. You know, if you stuck your hand
29 too far, you would get scratched or grabbed or
30 whatever.

31 Q. And in your experience at
32 Caressant Care, did any of the sharps

1 containers ever get, you know, damaged such
2 that you would suspect somebody was into the
3 sharps container?

4 A. No.

5 Q. Okay. So we have talked
6 about non-controlled drugs and the pharmacist
7 coming in, everything goes into a bag, water,
8 whatever the substance is, you indicated after
9 a time it becomes a big mess, blob?

10 A. Mass.

11 Q. Mass. When the pharmacist is
12 doing that, is he or she doing it with a nurse?

13 A. Yes.

14 Q. And at the same time are they
15 identifying what is being denatured, Joe
16 Smith's cycle pack for the last --

17 A. They would talk about why the
18 medication was there.

19 Q. But any counting of Joe Smith
20 went to the hospital on Wednesday, we are now
21 throwing away two cycle packs?

22 A. No, there was no counting.

23 Q. So for non-controlled drugs,
24 they simply got denatured, no counting?

25 A. That's correct.

26 Q. Okay. Now, I understand
27 there is a separate system with respect to
28 controlled drugs?

29 A. That's correct.

30 Q. Okay. So if we can go to
31 paragraph 54 of your affidavit:

32 "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

1 patch would there be?

2 A. A fentanyl patch.

3 Q. "[...] or whatever it may be,
4 and if there's a discrepancy she
5 talks to me about it. Only the
6 Pharmacy Consultant and I had
7 keys to the narcotic destruction
8 box. Usually it was the
9 Pharmacy Consultant and the
10 Charge Nurse that did the
11 destruction."

12 So let's unpack that a moment.

13 So these are narcotics to be
14 destroyed. So if we take Mr. Smith goes to the
15 hospital and is admitted, would his narcotics
16 for the week also have to be destroyed?

17 A. No, because that -- it wasn't
18 a weekly card, so it was, you know, an ongoing
19 card. So you would just start where it left
20 off when he came back from hospital.

21 Q. So under what circumstances
22 would a narcotic card with narcotics left in it
23 be put in this narcotic destruction box?

24 A. Well, if the resident didn't
25 need it anymore or the resident died or the
26 resident was transferred out of the facility.

27 Q. So when you indicate didn't
28 need it anymore, could that be a change of
29 doctor's orders then?

30 A. Yes. So they might have
31 Tylenol number 2. It is not effective anymore,
32 so then the doctor might order Tylenol number 3

1 or Dilaudid or something stronger and we would
2 get rid of the other.

3 Q. So your evidence was both the
4 narcotic card and the narcotic sheet go into
5 that box?

6 A. Yes, and they would be
7 wrapped together to make it easy for the
8 destruction and the Pharmacy Consultant to see
9 what was there.

10 Q. And so what does that sheet
11 tell the Pharmacy Consultant?

12 A. The sheet would tell the
13 Pharmacy Consultant how many medications were
14 supposed to be in the card and she would look
15 at the card and see that everything was okay.

16 Then she would punch the pills
17 out into another, you know, double-bagged
18 plastic bag, and -- or it could be the same bag
19 if she was doing everything that day, and
20 denature them.

21 Q. The same type of process that
22 we talked about earlier?

23 A. That's correct.

24 Q. Okay. And if there is a
25 discrepancy, if he or she, the pharmacist, is
26 looking at the count sheet and it is down to 15
27 remaining and on the card there's two, on the
28 card there's only two pills in the card, what
29 is the process?

30 A. Well, she would come to me
31 and point out the problem and I would call the
32 police.

1 Q. The narcotic destruction box,
2 although the nurses can get into the medication
3 room, I think your evidence was only you and
4 the Pharmacy Consultant could actually get into
5 that box; is that correct?

6 A. That's right. I had a key in
7 case someone threw something in there
8 inadvertently and needed it back out.

9 Q. So --

10 A. I never used it.

11 Q. So is it your evidence then
12 that it would be the Pharmacy Consultant that
13 would use it?

14 A. Yes, I never had need to use
15 my key for that purpose.

16 Q. And if I could turn,
17 Commissioner, this is not an exhibit in your
18 affidavit, but it is in the Overview Report,
19 Exhibit No. 6. If I can turn to document
20 00623, because I think this will assist in
21 helping our understanding of this process.

22 A. And where do I find that,
23 sorry?

24 Q. You are going to have to read
25 it on the screen in front of you, Mrs. Crombez.

26 And this is a Critical Incident
27 Report dated April 16th, 2013; is that correct?

28 A. That's correct.

29 Q. And the date and time of the
30 incident is April 16th, 2013, 17:10, and the
31 date and time it is submitted is the same date
32 17:19, nine minutes later; do you see that?

10:58:37 1
10:58:37 2
10:58:40 3
10:58:44 4
10:58:45 5
10:58:45 6
10:58:47 7
10:58:49 8
10:58:52 9
10:58:54 10
10:58:55 11
10:58:58 12
10:59:00 13
10:59:04 14
10:59:06 15
10:59:07 16
10:59:11 17
10:59:15 18
10:59:18 19
10:59:19 20
10:59:21 21
10:59:26 22
10:59:27 23
10:59:32 24
10:59:35 25
10:59:36 26
10:59:39 27
10:59:40 28
10:59:43 29
10:59:50 30
10:59:51 31
10:59:52 32

A. Yes.

Q. And it identifies, if we scroll down, the location is "med room Section B"?

A. Yes.

Q. And then in the description of the incident it states:

"Today our Pharmacy Consultant, Candace Pink, reported to us that when she was in to destroy meds she found an individual narcotic card of 31 tablets of hydromorphone 1 mg. missing. It appears that the tablets were put in the medication destruction box by Lois Durbidge, RN and Jennifer Hague RN on March 21, 2013."

So let me just ask one question. When as a nurse I'm going to put something into the drug narcotic box, destruction box, do I have to have a witness?

A. Yes. We needed two people to see it, two nurses to see it go into that box.

Q. Is that the same process with the non-controlled drug box?

A. No.

Q. So if I am getting rid of Mr. Smith's extra cycle packs because his medication has been changed, I can do that myself?

A. That's correct.

1 Q. But your evidence is that if
2 it is a narcotic, someone has got to watch me
3 do that?

4 A. That's correct.

5 Q. And would that be why it
6 refers to it appears that the tablets were put
7 in the medication destruction box by Lois
8 Durbidge and Jennifer Hague on March 21st?

9 A. Yes.

10 Q. So would they have to sign
11 off that is the actually date they put it in
12 the drug destruction box?

13 A. That's correct.

14 Q. It goes on to state:

15 "Police have been called and an
16 investigation will take place
17 starting tomorrow morning
18 possibly at 6:30 a.m. as the
19 police advised us to call them
20 in the morning to start the
21 investigation when both of these
22 staff members are working."

23 Now, I note here that the date
24 that the tablets were put in the box is March
25 21st, and am I right that the date it was
26 discovered is almost a month later, April 16th,
27 2013?

28 A. That's correct.

29 Q. And so between those two
30 dates, would there be more than one individual
31 that would have access to the medication room
32 in Section B?

11:01:00 1 A. Yes, certainly.

11:01:01 2 Q. It would be a different nurse

11:01:03 3 every shift; am I right on that?

11:01:05 4 A. Yes.

11:01:05 5 Q. And then if we go to "Actions

11:01:12 6 taken," it states:

11:01:20 7 "Investigation taking place.

11:01:22 8 Narcotic Disposal Box inspected

11:01:25 9 by B. Van Quaethem and H.

11:01:27 10 Crombez April 16/13 and found to

11:01:31 11 have a gap where possibly a

11:01:33 12 medication card could be removed

11:01:35 13 by sticking your hand in or

11:01:37 14 using tongs."

11:01:41 15 So you and Ms. Van Quaethem

11:01:42 16 discovered that, did you?

11:01:44 17 A. Yes.

11:01:46 18 Q. "We showed C. Pink this and

11:01:48 19 she has put in a request for

11:01:50 20 equipment service to this box or

11:01:51 21 a replacement for this box.

11:01:53 22 Request is marked as 'urgent'."

11:01:58 23 Are those boxes provided by the

11:02:00 24 pharmacy then?

11:02:00 25 A. Yes, they are.

11:02:01 26 Q. "Constable McLeod in this

11:02:06 27 morning, April 17, 2013. He

11:02:09 28 spoke with B. Van Quaethem and

11:02:11 29 H. Crombez regarding the process

11:02:14 30 of medication disposal and

11:02:16 31 examined the Narcotic Disposal

11:02:18 32 Box. He interviewed both J.

11:02:20 1 Hague and L. Durbidge privately
11:02:22 2 in the office. Constable McLeod
11:02:33 3 took a list of names of
11:02:34 4 registered staff, RN and RPN,
11:02:36 5 that work here and also a list
11:02:38 6 of staff who worked night shift
11:02:40 7 alone on this side of the
11:02:41 8 building. He said he would run
11:02:43 9 some names through their
11:02:44 10 computer, looking at spouses,
11:02:46 11 addresses, etc. He is involved
11:02:48 12 in drug investigations in
11:02:49 13 Woodstock and knows this
11:02:50 14 medication is available on the
11:02:51 15 street. He said he may work
11:02:53 16 backwards and talk to people who
11:02:54 17 deal in drugs and see what he
11:02:55 18 can shake out."

11:02:56 19 To the best of your knowledge,
11:03:01 20 was there anyone charged with this particular
11:03:03 21 missing narcotic in your home?

11:03:04 22 A. I can't recall. I don't
11:03:08 23 believe there was.

11:03:09 24 Q. Do you remember ever
11:03:10 25 disciplining anybody for having taken 31 --

11:03:17 26 A. No, I don't recall.

11:03:19 27 Q. All right. And would you
11:03:21 28 have cooperated with the police and provided
11:03:24 29 them with a list of all of the individuals who
11:03:27 30 would have had access to that medication room
11:03:29 31 between those two dates?

11:03:30 32 A. Certainly I would have given

1 him names and phone numbers.

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

4 "Investigation ongoing.
5 Narcotic Disposal Box was
6 replaced with a newer, more
7 secure model April 17/13. It
8 was also screwed to the cement
9 floor from inside the box to
10 make stealing from it more
11 difficult.

12 Investigating at present.
13 Approval has been received from
14 Head Office to install a hidden
15 security camera as this was a
16 suggestion made by the police
17 officer. B. Van Quaethem has
18 contacted A. LeBell, IT,
19 regarding this."

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

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

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

29 A. I don't know.

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

1 A. Well, you know, I would say
2 things like, oh, you know, candid camera, you
3 never know.

4 Q. Okay. So now I want to talk
5 about insulin. Insulin, as I understand your
6 affidavit, is not a controlled drug?

7 A. That's correct.

8 MS. HEWITT: Commissioner, would
9 you like us to -- I'm getting
10 into a whole new area, would you
11 like to take the morning break?
12 I'm in your hands.

13 THE COMMISSIONER: How long are
14 you going to be in this area?

15 MS. HEWITT: Quite awhile,
16 because it is the whole handling
17 of insulin.

18 THE COMMISSIONER: No, I think
19 it would be wise to take the
20 morning break now.

21 Just before we do that, I had an
22 email suggesting that we might
23 need to make a change to the
24 lunch recess time.

25 MS. HEWITT: There is a request
26 to make that change. I haven't
27 canvassed counsel, but I am
28 going to suggest it is probably
29 we would rather make that change
30 for Monday. It is a Friday, and
31 so rather than sitting a little
32 later and having a longer lunch,

11:06:01 1 I suspect counsel would rather
11:06:04 2 go back to Toronto, so the
11:06:06 3 suggestion was a longer lunch
11:06:07 4 hour because we know that
11:06:09 5 everybody is cooperating with
11:06:11 6 each other, but sit for 15
11:06:14 7 minutes more. So it is my
11:06:17 8 suggestion that we potentially
11:06:18 9 start that on Monday?
11:06:23 10 THE COMMISSIONER: So today is
11:06:24 11 going to be a normal lunch hour
11:06:25 12 and a normal closing time, but
11:06:27 13 going forward, starting on
11:06:28 14 Monday, the lunch hour will be
11:06:30 15 an hour and 15 minutes, and
11:06:34 16 correspondingly 15 minutes later
11:06:38 17 at closing each day?
11:06:39 18 MS. HEWITT: Yes, and that is to
11:06:40 19 give everybody the opportunity
11:06:41 20 to -- there is a lot of
11:06:42 21 conferring to try to make this
11:06:44 22 process more expeditious during
11:06:46 23 the lunch hour, so it shortens
11:06:48 24 any ability for anybody to
11:06:49 25 actually go out of the building
11:06:50 26 and get nourishment.
11:06:52 27 THE COMMISSIONER: Yes. No,
11:06:54 28 everybody needs to have a health
11:06:55 29 break and food, but I understand
11:06:58 30 that there's lots that happens
11:07:00 31 behind the scenes at lunchtime
11:07:01 32 and that makes sense.

11:07:03 1 MR. SANDLER: Actually, the
11:07:04 2 Inquiry would move much more
11:07:06 3 quickly, Commissioner, if we
11:07:08 4 were precluded from having food
11:07:09 5 and drink at any time.
11:07:11 6 THE COMMISSIONER: It might be
11:07:11 7 hard for anybody with diabetes,
11:07:13 8 but we won't go there. All
11:07:15 9 right, thank you, so we'll take
11:07:16 10 our 15-minute recess now.
11:07:19 11 -- RECESSED AT 11:07 A.M.
11:16:54 12 -- RESUMED AT 11:25 A.M.
11:26:07 13 BY MS. HEWITT:
11:26:07 14 Q. Thank you, Commissioner.
11:26:08 15 Now, Helen, I wanted to talk
11:26:11 16 about insulin, and we do know that we are going
11:26:14 17 to have Registered Nurses here throughout the
11:26:16 18 Inquiry at times, so I understand in your
11:26:20 19 affidavit you have identified you haven't given
11:26:23 20 insulin in quite some time in your career; is
11:26:25 21 that correct?
11:26:25 22 A. That's correct.
11:26:26 23 Q. But in general, you are aware
11:26:28 24 of the way that insulin was handled within
11:26:31 25 Caressant Care?
11:26:31 26 A. I believe I do.
11:26:35 27 Q. So I'm going to do the same
11:26:37 28 thing that I just did with respect to the
11:26:39 29 medication management, is go through your
11:26:42 30 affidavit and then we'll stop and I'll ask some
11:26:46 31 clarification questions.
11:26:47 32 So if I can turn you then to the

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

9 So at paragraph 59a. it
10 identifies:

11 "The insulin cartridges come in
12 a box."

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

17 A. Yes, that's correct.

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

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

25 And an expiry date; is that
26 correct?

27 A. That's correct.

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

30 A. Once insulin was removed from
31 the fridge, it had a life of 30 days, and the
32 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 1 4:30-5:00 p.m. They were
11:29:52 2 delivered by a delivery service
11:29:53 3 contracted by the pharmacy."

11:29:55 4 A. Yes.

11:29:56 5 Q. And then you go on to talk
11:29:58 6 about the medications being in a big bag and
11:30:01 7 the narcotics. Would the insulin cartridges
11:30:03 8 package or insulin boxes of cartridges be
11:30:11 9 packaged separately from the cycle strips and
11:30:14 10 the narcotics or all in the same bag, or how
11:30:17 11 would that happen?

11:30:18 12 A. It would be separate from the
11:30:20 13 cycle-fill. It would be in that paper bag, I
11:30:22 14 believe.

11:30:22 15 Q. But packaged on its own?

11:30:24 16 A. Packaged on its own.

11:30:27 17 Q. In paragraph e. you indicate:
11:30:32 18 "The delivery person would go to
11:30:33 19 the nurse in charge, say that he
11:30:35 20 has the medications [...]"
11:30:37 21 And this is all the medications,
11:30:40 22 correct?

11:30:41 23 A. That's correct.

11:30:43 24 "[...] she would walk to the
11:30:44 25 medication room, sign that she
11:30:45 26 had received the medications and
11:30:46 27 the narcotics. There was a form
11:30:47 28 to sign in the medication room.
11:30:49 29 The delivery person would sign
11:30:50 30 that he/she had delivered and
11:30:52 31 the nurse would initial that it
11:30:54 32 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 1 Q. Okay. You go on to say in
11:32:07 2 g.:

11:32:07 3 "The insulin is refrigerated.
11:32:09 4 Caressant Care had three
11:32:10 5 refrigerators, one of each of
11:32:12 6 Level 1 and Level 2 in their
11:32:15 7 respective medication rooms and
11:32:16 8 one in Section B in the room
11:32:17 9 right next to the medication
11:32:19 10 room, which is also locked."
11:32:24 11 I believe you indicated
11:32:25 12 yesterday that that was -- you referred to that
11:32:27 13 as the treatment room?

11:32:29 14 A. I called it the treatment
11:32:30 15 room, but the title on the door was the exam
11:32:32 16 room.

11:32:32 17 Q. On the drawing that we were
11:32:34 18 looking at?

11:32:35 19 A. Yes, uhm-hmm.

11:32:35 20 Q. Thank you:
11:32:37 21 "Section B also had a small
11:32:38 22 locked fridge strictly for
11:32:40 23 vaccine storage."
11:32:42 24 So in respect of insulin, was it
11:32:44 25 always stored in fridges in locked rooms?

11:32:48 26 A. Yes.

11:32:49 27 Q. Would there be a lock on the
11:32:52 28 fridge?

11:32:52 29 A. Not for the medication
11:32:55 30 fridge, no.

11:32:55 31 Q. And when you say that, it
11:32:59 32 begs the question, was there any other fridge

1 that would have been locked?

2 A. Well, the vaccine fridge was
3 locked.

4 Q. And why would that fridge be
5 locked versus the fridge where items such as
6 insulin are kept?

7 A. Well, we didn't want anyone
8 else -- we didn't want anything else to go into
9 that fridge. It was strictly to be for
10 vaccines, and the time that we used it most was
11 for flu season, to give that vaccination.

12 Q. And in the fridges in which
13 insulin is stored, are there any other things
14 stored in those fridges?

15 A. There would be some ginger
16 ale in there. What else did we have in there?
17 The --

18 Q. Is that for residents' use?

19 A. For residents' use. We would
20 give a supplement, resource 2.0, and there were
21 several other types of nutritional supplements
22 and they would be kept in there.

23 We gave medications with apple
24 sauce or pudding, and if it was an open jar of
25 apple sauce, then that would be kept in there.

26 Q. Now, when the insulin boxes
27 were put into the fridge, did they have
28 separate resident bins in the fridge like the
29 medication cart does?

30 A. No, they would be kind of
31 stacked in rows on the shelf.

32 Q. All right. And would they be

11:34:40 1 separated in any particular manner?
11:34:42 2 A. Not -- I think they usually
11:34:46 3 had an elastic around them, like, you know, if
11:34:49 4 it were two or three boxes, then they would
11:34:52 5 have an elastic around them, I believe.
11:34:54 6 Q. And by that do you mean if
11:34:56 7 there were two or three boxes for any
11:34:57 8 particular resident?
11:34:58 9 A. That's correct.
11:34:59 10 Q. And I think your affidavit
11:35:01 11 indicates that some residents may be on more
11:35:05 12 than one type of insulin?
11:35:06 13 A. That's correct.
11:35:07 14 Q. So in the fridge they may
11:35:11 15 have more than one, at any given time they may
11:35:14 16 have more than one box of insulin cartridges?
11:35:16 17 A. That's correct.
11:35:17 18 Q. And I think your evidence
11:35:19 19 just was that they may be elasticized together
11:35:22 20 in the fridge?
11:35:23 21 A. Uhm-hmm.
11:35:23 22 Q. Okay, thank you. You go on
11:35:28 23 to say that:
11:35:30 24 "The individual cartridges
11:35:34 25 [...]"
11:35:34 26 And this would be the cartridges
11:35:35 27 that contain the insulin; correct?
11:35:38 28 A. That's correct.
11:35:39 29 Q. "[...] do not have the
11:35:41 30 resident's name on it.
11:35:42 31 Caressant Care had a plastic
11:35:44 32 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

1 entered through the nurse.

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

7 A. No, we had no such
8 requirement.

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

11 "The cartridges contain 3
12 millilitres."

13 Is that correct?

14 A. Yes.

15 Q. "There are 100 units per ml,"
16 we are going to do some math
17 now, Commissioner, "and
18 therefore each cartridge holds
19 300 units [of insulin]."

20 Is that correct?

21 A. Yes.

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

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

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

11:38:12 1 needed if the resident's blood sugar was
11:38:18 2 between this and that, and then so many units
11:38:21 3 of insulin if the blood sugar was higher from
11:38:27 4 this to that. And there might be three such
11:38:31 5 doses listed.

11:38:32 6 Q. So for insulin that is
11:38:37 7 prescribed on a sliding scale, does that
11:38:40 8 require the blood sugars to then be taken
11:38:43 9 before the insulin is given?

11:38:45 10 A. Yes, each time.

11:38:46 11 Q. Okay. And so again, it may
11:38:51 12 just be a tad easier to see something in
11:38:56 13 action, Commissioner, so if I can turn you to
11:38:59 14 doc ID 11569. It is not in the affidavit. It
11:39:06 15 is in the Overview Report.

11:39:08 16 It does refer to one of the
11:39:10 17 victims, so I apologize to the victim's family,
11:39:14 18 Clotilde Adriano, if they are watching, but
11:39:17 19 educationally-wise I thought it might be
11:39:19 20 beneficial to the Commission.

11:39:21 21 And if we could go to page
11:39:45 22 number 9 of that document. Do you recognize
11:39:54 23 what this document is, the type of document it
11:39:57 24 is, Helen?

11:39:57 25 A. Yes.

11:39:59 26 Q. And what is this document?

11:40:00 27 A. This is a paper Medication
11:40:05 28 Administration Record.

11:40:05 29 Q. Okay. And on the left-hand
11:40:07 30 side, the left-hand column, without talking
11:40:10 31 about what is there right now, what does that
11:40:12 32 generally signify to the nursing staff?

11:40:17 1 A. Sorry, what are you referring
11:40:20 2 to?

11:40:20 3 Q. Let's just talk the first
11:40:22 4 one, "insulin, Novolin cc 30/70". What is
11:40:28 5 "30/70"?

11:40:28 6 A. That is the type of insulin
11:40:30 7 to be given.

11:40:30 8 Q. "45 u", what is that --

11:40:33 9 A. That is every morning.

11:40:34 10 Q. Just let me catch up. So "q
11:40:39 11 am" means every morning?

11:40:40 12 A. Yes.

11:40:41 13 Q. And under "Hours" it says
11:40:46 14 07:30, what does that signify?

11:40:48 15 A. What type it should be given.

11:40:50 16 Q. Okay. And then there is an
11:40:53 17 arrow beside the 07:30 going over to March 6th,
11:41:02 18 2007 and then from then on until the 23rd, what
11:41:05 19 is that that we are saying?

11:41:07 20 A. There was a change in
11:41:09 21 direction, I believe.

11:41:10 22 Q. All right, but what are we
11:41:12 23 seeing in those boxes?

11:41:13 24 A. The signatures of the nurses
11:41:16 25 who gave the medication.

11:41:17 26 Q. All right. So when you were
11:41:19 27 on the paper medication administration system,
11:41:23 28 they would have to actually initial every
11:41:26 29 single time they gave this medication?

11:41:28 30 A. That's correct.

11:41:28 31 Q. And when you were on the
11:41:29 32 paper, did that -- was that for all drugs that

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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 1 Q. Yes?

11:42:51 2 A. And then if we look down on

11:42:54 3 the 24th at 7:30, this new change took place,

11:42:59 4 and if we look at the medication underneath,

11:43:03 5 that change took place on the 23rd at 16:30.

11:43:07 6 Q. So the Novolin that was being

11:43:15 7 given every morning between March the 6th and

11:43:22 8 March the 23rd, which was 45 units of Novolin

11:43:28 9 30/70, was changed towards the end of the month

11:43:29 10 to 40 units in the morning; is that correct?

11:43:32 11 A. That's correct.

11:43:35 12 Q. And similarly the 16:30 dose

11:43:38 13 was changed, if I'm reading this right, from 40

11:43:41 14 units to 20 units; is that correct?

11:43:43 15 A. Yes.

11:43:44 16 Q. Now, would these -- is this a

11:43:47 17 doctor's order?

11:43:48 18 A. Yes, the change wouldn't have

11:43:50 19 been made unless it was a doctor's order.

11:43:52 20 Q. All right. But this

11:43:53 21 particular sheet that we are looking at, is

11:43:56 22 that a doctor's order?

11:43:57 23 A. No, this is a Medication

11:43:59 24 Administration Record.

11:43:59 25 Q. All right. So there would be

11:44:00 26 a separate doctor's order for that change?

11:44:03 27 A. Yes.

11:44:04 28 Q. And then if we can just

11:44:06 29 scroll down a bit further, there's two lines

11:44:14 30 for 16:30 and 07:30 with no "X's" or no

11:44:22 31 slashes. And what would that signify to you?

11:44:27 32 A. Sorry, say this again?

1 Q. If you scroll down to the
2 last two entries, we now have "Novolin 30/70,
3 20 units p.m., 16:30 Novolin 30/70 30 units q
4 am", and those don't have a slash in them like
5 the ones above. So what does that mean --

6 A. The arrow indicates that it,
7 you know, started on the 29th.

8 Q. So this was another change?

9 A. Another change.

10 Q. All right. And then so in
11 the course of this month, there were two new
12 medication changes for insulin, actually four
13 if we count the two different times; correct?

14 A. Correct.

15 Q. And all of those changes
16 would have to be understood by the nursing
17 staff and then the correct dosage provided; is
18 that correct?

19 A. That's correct.

20 Q. All right, thank you.

21 So if we go back to your
22 affidavit, we were talking hypothetically that
23 you are inserting a cartridge, a new cartridge
24 into the pen, and then once -- sorry, at page
25 number 14, paragraph o. -- first of all, I'm
26 assuming you actually -- how do you actually
27 get the cartridge into the pen?

28 A. I believe you unscrew it,
29 snap the cartridge in and screw it back
30 together.

31 Q. Okay. And the pen, when you
32 do that, is there already a needle attached?

1 A. No, we had a box of needles
2 or tips and they would put a new tip on with
3 each administration.

4 Q. So each and every time that
5 injectable insulin is given, they would have to
6 insert a needle into the end of the cartridge?

7 A. That's right.

8 Q. Okay. Now, when you did
9 that, in number o. you say:

10 "In order to use the pen, you
11 would insert a needle and prime
12 it. Usually a drop or two.
13 Then you would dial up the dose
14 that was needed."

15 So what do you mean by priming?

16 A. You wanted to make sure that
17 the insulin would be measured accurately, so
18 the insulin had to be right into the needle and
19 into the barrel of the needle, so you would
20 prime it until you saw a little drop come out.

21 Q. And to prime it, just in the
22 medication room, over a sink, over a garbage,
23 or is there any --

24 A. They usually did that in the
25 medication room, I believe.

26 Q. Okay.

27 A. Or, you know, you could do it
28 on your treatment card over a Kleenex or a
29 piece of paper towel or whatever.

30 Q. You indicate that you needed
31 to, in that same paragraph:

32 "Then you would dial up the dose

11:47:53 1 that was needed."

11:47:54 2 What do you mean "dial up"?

11:47:57 3 A. There was an indicator on the

11:48:01 4 pen as to how many units and you would twist

11:48:03 5 the end until you got to the right number.

11:48:05 6 Q. So. For instance, for Ms.

11:48:10 7 Adriano, if I needed 40 units, you are saying

11:48:14 8 you would dial up to the number 40?

11:48:19 9 A. Yes.

11:48:19 10 Q. And when we are talking about

11:48:20 11 300 units in a pen, would you be able to

11:48:26 12 decipher yourself without that counting

11:48:29 13 mechanism what is 30 or 40 units?

11:48:34 14 A. No, you couldn't see that.

11:48:36 15 Q. All right, so --

11:48:36 16 A. Accurately enough.

11:48:37 17 Q. So it is the pen that

11:48:38 18 actually allows you to be accurate as to the

11:48:42 19 number of units you are about to administer?

11:48:44 20 A. That's correct.

11:48:45 21 Q. And then you go on to say:

11:48:52 22 "Once the insulin is injected

11:48:53 23 into the resident the dial goes

11:48:55 24 back to 0."

11:48:58 25 Now, before that, there is the

11:49:00 26 whole thing you talked about this morning, the

11:49:02 27 nurse would have to determine the right

11:49:04 28 resident, the right dosage, the right delivery

11:49:07 29 system, et cetera; is that correct?

11:49:08 30 A. That's correct.

11:49:09 31 Q. Now, when you say the dial

11:49:11 32 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 1 nurse there, as I understand your evidence,
11:50:27 2 someone watching them and to whom they hand the
11:50:31 3 pen to say, have I dialled up 40 units?

11:50:34 4 A. They might, if they were
11:50:37 5 working in the same area, but that was highly
11:50:39 6 unlikely.

11:50:40 7 Q. So generally speaking, I
11:50:42 8 think your earlier evidence was that the RPNs
11:50:45 9 and the RNs were assigned their own block of
11:50:48 10 residents; is that correct?

11:50:49 11 A. That's correct, and they
11:50:50 12 would be, you know, somewhere down the hallway.

11:50:53 13 Q. And are insulin -- is insulin
11:50:57 14 generally given around meal times?

11:51:01 15 A. Yes. It would depend on what
11:51:05 16 type of insulin it was. The fast-acting
11:51:10 17 insulins we wanted given after meals to make
11:51:12 18 sure that the resident had eaten enough food to
11:51:19 19 use the insulin.

11:51:20 20 Q. And so let me ask you this
11:51:30 21 question. Can I take Mr. Smith's and Sally's
11:51:36 22 and Jane's pens and dial them all up all at
11:51:41 23 once and put them on my cart, so that when I
11:51:43 24 reach them, I can just give it to them?

11:51:45 25 A. That wasn't the process. You
11:51:50 26 would dial up at -- you know, you would park
11:51:56 27 your cart close to where the resident was and
11:51:58 28 then check your administration record for how
11:52:01 29 many units and then dial up.

11:52:04 30 Q. And then would I have to
11:52:09 31 repeat that for every one of my residents that
11:52:12 32 was on insulin?

11:52:13 1 A. That's correct.

11:52:13 2 Q. And not every long-term care

11:52:16 3 resident is on insulin?

11:52:17 4 A. That's correct. Some might

11:52:21 5 be on an oral hypoglyceamic.

11:52:24 6 Q. And that would be a pill

11:52:27 7 form; correct?

11:52:27 8 A. A tablet, yes.

11:52:28 9 Q. A tablet. So in terms of if

11:52:35 10 there was to be an independent double-check by

11:52:37 11 another nursing staff, given who you had at --

11:52:42 12 the staffing levels you had at the home, where

11:52:45 13 would the first nurse draw the second person

11:52:49 14 from?

11:52:52 15 A. Well, if it was on day shift,

11:52:54 16 it would be easiest to draw the Charge Nurse.

11:52:58 17 Q. So they would have to locate

11:53:00 18 the Charge Nurse?

11:53:01 19 A. Uhm-hmm. She was usually at

11:53:02 20 the desk, I would think.

11:53:03 21 Q. Now, if they were going to do

11:53:05 22 that, would the Charge Nurse have to look at

11:53:07 23 the Medication Administration Record and the

11:53:09 24 pen?

11:53:09 25 A. She would have to go down and

11:53:11 26 double-check that, yes.

11:53:12 27 Q. All right. And they would

11:53:15 28 have to do that each and every time?

11:53:17 29 A. That's correct.

11:53:17 30 Q. All right. Now, in number

11:53:24 31 t. you say:

11:53:26 32 "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?

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A. That's correct.

Q. Now, let's talk about you have gone around and you have given most of your doses, but you get to Ms. Adriano who needs 40 units and it doesn't appear that there is sufficient insulin to do that 40 units.

A. Uhm-hmm.

Q. You have indicated in number v. of your affidavit:

"Hypothetically, if there is not enough insulin left in the cartridge to give the resident the full dose, I would throw the cartridge away. I wouldn't want to inject a resident more than once."

So it is not possible to have one insulin cartridge and then insert another and keep dialling up? You are saying it would actually require two injections into the resident, one to finish the first cartridge and then the second to continue whatever dose you needed?

A. I believe so. You had to prime it in between, right, so I don't know. When you talk to your nurses, that might be a good question for them.

Q. All right. And we prefaced the whole thing by saying this is your understanding, so we appreciate that. That is why the actual things will be going through the 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

1 those would be thrown in the non-controlled
2 drug destruction box or the sharps container;
3 is that correct?

4 A. Yes. The only time that it
5 might be reallocated to another resident is if
6 the Pharmacy Consultant happened to be there on
7 that day and she could make a new label, you
8 know, for the box, just a handwritten label,
9 but that didn't happen very often.

10 Q. Yes, okay, but other than
11 that, it would be the process -- you believe it
12 was the process you have described which was
13 the non-controlled drug destruction box or the
14 sharps container, and you indicated earlier
15 that when those things were thrown away, there
16 didn't need to be somebody there to sign; there
17 wasn't a double signing of it, is that correct?

18 A. Yes.

19 Q. And then when they were
20 actually denatured, there wasn't any count or
21 trace done of it at that point in time either?

22 A. Yes.

23 Q. And then finally at number z.
24 you say:

25 "The pharmacy does provide drug
26 utilization statistics. We
27 reviewed it yearly. Those
28 statistics were more focussed on
29 tranquilizers, pain medication,
30 psychotropics. I do not recall
31 any drug utilization statistics
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 1 A. Well, she seemed very nice
12:00:17 2 and pleasant. She spoke well. She looked
12:00:24 3 well. She seemed happy.

12:00:31 4 Q. And what would be the next
12:00:33 5 step in your process then regarding making sure
12:00:36 6 that Elizabeth Wettlaufer was qualified for
12:00:39 7 your home?

12:00:40 8 A. Well, I would have checked
12:00:43 9 her registration online with the College of
12:00:50 10 Nurses.

12:00:50 11 Q. Now, let me just stop you
12:00:52 12 there just a second because we'll see some
12:00:58 13 evidence later on in the Inquiry about a
12:01:01 14 website called "Find a Nurse," and was that
12:01:06 15 website available to you in 2007, do you know?

12:01:10 16 A. It might not have been. Then
12:01:15 17 she would have shown me her registration card.

12:01:17 18 Q. All right, but would you
12:01:20 19 check that with the College of Nurses?

12:01:21 20 A. No, I would check the date on
12:01:22 21 the registration card, and if it was good until
12:01:29 22 -- I forget what date it says, if it was
12:01:31 23 December or January, but then she would be
12:01:36 24 registered.

12:01:37 25 Q. Okay. Were you aware at that
12:01:39 26 point in time as to whether there was any
12:01:43 27 conditions of her registration?

12:01:45 28 A. No.

12:01:46 29 Q. All right. Now, in terms of
12:01:53 30 her references, let's first turn to her resumé.
12:02:00 31 She submitted a resumé to you, did she not?

12:02:03 32 A. Yes, she did.

1 Q. All right, let's just see
2 what that resumé says. If I can turn you,
3 Commissioner, to tab C, document 57084. And it
4 is the second document at tab C. Helen, are
5 you there? Have you found it?

6 A. Yes, I have found it.

7 Q. So just briefly, she
8 describes herself as working at Christian
9 Horizons:

10 "Job title - support worker: I
11 am part of a team which assists
12 five developmentally challenged
13 individuals who live together in
14 a group home. My duties include
15 administering medication and
16 assisting the individuals in all
17 aspects of their daily living
18 including bathing, personal
19 hygiene, food preparation and
20 clean up, laundry, and community
21 outings. I am also responsible
22 for coordinating training for
23 other staff members in the area
24 of medication administration and
25 for ensuring staff regularly
26 review medication procedures,
27 classifications and side
28 effects. Doing so, combined
29 with assisting the individuals
30 to learn how to perform aspects
31 of their own care has helped me
32 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?

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A. That's correct.

Q. And this says "General Orientation - All Employees." Was there also any orientation given to registered staff, or is this the extent in 2007?

A. I can't recall.

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?

A. That's correct.

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?

A. I believe that is Marie Buckrell's writing on it, so I believe it was added at the time.

Q. Now, I understand from paragraph 80 of your affidavit that Elizabeth Wettlaufer initially was hired to work all shifts; is that correct?

A. That's correct.

Q. And that was a part-time position?

A. Yes.

Q. And then paragraph 80 indicates that you believe she went full-time evenings and nights in Section B?

A. Yes.

Q. And then full-time evening and nights in Section A?

1 A. Yes.

2 Q. All right. Now, we have
3 heard some discussion regarding staffing levels
4 in long-term care and in Caressant Care. So we
5 have endeavoured, Commissioner, to attempt to
6 make this slightly easier for everyone, and if
7 you can just give me a moment, if I can turn
8 you to tab E of your affidavit, document number
9 72518.

10 A. Yes.

11 Q. And if we can rotate that,
12 please. Now, I understand from your affidavit
13 you are retired now; is that correct?

14 A. That's correct.

15 Q. And this document has been
16 developed for the benefit of the Commission and
17 the Commissioner by the current staff at
18 Caressant Care; is that correct?

19 A. Yes.

20 Q. But to the best of your
21 recollection, does this adequately portray the
22 staffing levels and changes during the period
23 that Elizabeth Wettlaufer was with Caressant
24 Care?

25 A. Yes.

26 Q. So we'll just take a few
27 minutes, Commissioner, to look at this
28 document.

29 In 2007, when she starts, you
30 indicated that she could be on all three
31 shifts; is that right?

32 A. That's correct.

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Q. And part-time?

A. Yes.

Q. So if we look at 2007, the shift, it has "D," "E" and "N." What do you understand those to mean?

A. The "D" is for days, "E" is for evenings, and "N" is for nights.

Q. And then there is a tab up at the top, the first box says "RN," that would be Registered Nurses?

A. Yes.

Q. Now, this chart is a little skewed off, but my understanding, the first row of numbers, you can't really see it, Commissioner, but it is bolded. Under the 3, 2, 1, what did you understand that to be on days 3 --

A. That is the total number of Registered Nurses on that shift.

Q. Okay. And then across from the 3 is 1, 1 and 1?

A. So there was 1 Registered Nurse on Section B, one on Level 1 and one on Level 2.

Q. Thank you. And then if we keep on days and go over to RPNs?

A. There were two RPNs in Section B.

Q. And there were 18 PSWs then, is that correct, altogether on day shift?

A. Correct.

Q. If you go over to PSWs?

12:11:42 1 A. Yes.

12:11:42 2 Q. Okay.

12:11:43 3 A. In total, uhm-hmm.

12:11:44 4 Q. So if we go down to evenings

12:11:47 5 and nights, on evenings it identifies that you

12:11:52 6 would have two RNs and two RPNs working as of

12:11:59 7 2007?

12:11:59 8 A. Yes.

12:12:00 9 Q. And then nights, you had one

12:12:02 10 RN in the building and one RPN; is that

12:12:05 11 correct?

12:12:05 12 A. That's correct.

12:12:06 13 Q. Now, I hate to do math but we

12:12:10 14 are going to do a bit of math. Refresh our

12:12:13 15 memory, if you can, in Section B the number of

12:12:18 16 residents, approximately?

12:12:25 17 A. In 2007 there would be 90, at

12:12:29 18 least 90, maybe 95, I don't know.

12:12:31 19 Q. Approximately 90 to 95?

12:12:35 20 A. Yes.

12:12:35 21 Q. Level 1?

12:12:37 22 A. Oh, and yeah, it went up to

12:12:39 23 99, but I think in 2007 it wasn't, you know,

12:12:42 24 that full. That happened when Brenda was

12:12:47 25 there, I think, and she didn't come until

12:12:49 26 later.

12:12:52 27 Q. So approximately in the 90s

12:12:56 28 somewhere?

12:12:56 29 A. Uhm-hmm.

12:12:57 30 Q. And Level 1?

12:12:58 31 A. Again, it is just a guess, 32

12:13:03 32 or 34.

1 Q. All right. Somewhere between
2 30 and 35; is that accurate?

3 A. Yes. Well, we got the
4 licences at the same time, so it would be
5 either 30 or 32.

6 Q. Okay. And Level 2?

7 A. The same.

8 Q. So when there is a day shift,
9 you would have -- in 2007, you would have one
10 RN and two RPNs in Section B, the larger
11 portion of the home; am I reading that
12 correctly?

13 A. That's correct.

14 Q. Now, if I'm wrong, make sure
15 that you tell me. I can take it, okay.

16 And on evenings, you would have
17 one RN in Section B and then one RN -- now,
18 would that be looking over both Levels 1 and 2?

19 A. No, on Level 1 we would have
20 the RN, and on Level 2 we would have the RPN.

21 Q. Okay. And those individuals
22 would each be taking care of 30 to -- around 30
23 to 32 residents?

24 A. That's correct.

25 Q. All right. And then on
26 nights, in Section B the nurse, the RN would be
27 responsible for all 99 -- 90 to 99 residents?

28 A. Yes.

29 Q. And then the RPN would be
30 responsible -- now, it has the RPN under
31 Section B, but where would the RPN actually be
32 working?

1 A. The RPN would float between
2 Levels 1 and 2.

3 Q. All right. So one RN for
4 approximately 90 to 99 residents and one RPN
5 for approximately 60 to 64 residents?

6 A. That's correct.

7 Q. And then the next portion of
8 the chart is 2012, and we'll just talk about
9 the RNs for a minute, just to make it a little
10 easier. From my review of this document, did
11 your RN complement ever change between 2007 and
12 2014 on those shifts?

13 A. No.

14 Q. And the RPN complement, did
15 it remain the same until 2014?

16 A. Yes.

17 Q. And then what happened in
18 2014?

19 A. There were -- in 2014?

20 Q. Just in terms of --

21 A. One on Section B, it looks
22 like, one on Level 1 and one on Level 2.

23 Q. So you were able to hire
24 another RPN?

25 A. Yes.

26 Q. All right. And then the
27 chart on the right indicates that the PSW
28 complement has essentially, the total has
29 stayed the same but the allocation has changed?

30 A. Changed, yes.

31 Q. Now, again, this doesn't
32 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

1 4, and we did that.

2 Q. Now, I don't want to get into
3 the discussions about how things are funded in
4 long-term care or how staffing may have changed
5 in combination with funding, but what I do want
6 to ask you is we heard testimony yesterday
7 about how the acuity level of residents could
8 impact the level of funding that you would
9 receive.

10 In your experience, and it is a
11 long experience, so let's limit it to the last
12 decade that you were there, 2007 or so to 2017,
13 did you see a difference in the acuity level of
14 residents?

15 A. Yes, certainly. Residents
16 came in frailer, usually in a wheelchair. We
17 also had a lot of residents with behaviours.

18 Q. Do you mean more residents
19 with behaviours?

20 A. Yes. They might have managed
21 in the community, you know, for awhile living
22 in a group home, but their health or their
23 condition changed so that they needed more
24 care.

25 Q. All right, thank you, Helen.

26 Now, I want to talk about
27 Elizabeth Wettlaufer's performance in the early
28 years. From my review of your affidavit, it
29 indicates that by the end of 2008 she had one
30 counselling for absenteeism and four medication
31 errors.

32 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?

1 A. When the incident happened,
2 and I believe Marie must have thought that
3 Bethe was involved in some way, so whether she
4 was working nights and didn't check the
5 cycle-fill thoroughly or if there was an order
6 that was missed and it wasn't processed
7 properly.

8 Q. And this is -- we looked at a
9 medication error earlier today where the pill
10 was left in the narcotic card, and this is a
11 medication error where there was none found in
12 the cycle pack. Is that a different type of
13 medication error?

14 A. Well, one is administration,
15 and it is hard to say what this one is because
16 there is no documentation on it.

17 Q. Okay, thank you. Now, is
18 this form that we are looking at, is this a
19 computerized form?

20 A. Yes.

21 Q. And is it an internal form?

22 A. Yes, it is an internal
23 Resident Incident Report.

24 Q. And at this point in time
25 when this form would be filled out on your
26 computer system, would the form be provided in
27 any manner, in any way to the pharmacy?

28 A. No.

29 Q. Under what circumstances
30 would you report a medication error to the
31 pharmacy?

32 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.

1 Q. Is this something that, to
2 your experience, was changing in the industry
3 or had changed in the industry and Caressant
4 Care was catching up, or are you aware?

5 A. I believe that was the
6 reason.

7 Q. Which one; that it was a
8 change or that you were catching up?

9 A. That we were catching up,
10 probably.

11 Q. Okay. Now, if I can turn you
12 to the incident that happened on March 24th,
13 2008, which is document 16909. Let me just
14 find it, Commissioner.

15 Okay, I just have to find it in
16 my own book here. Here it is.

17 I just lost my concentration for
18 a minute there, Commissioner. Just --

19 THE COMMISSIONER: It is no
20 problem. You are looking for
21 document 16909, March 24, '08,
22 critical incident.

23 MS. HEWITT: I apologize again.

24 THE COMMISSIONER: Not at all.

25 Is it HH?

26 BY MS. HEWITT:

27 Q. Yes. Mr. Sandler was just
28 asking me if I was leaving out the error on
29 March the 23rd, 2008, but that is the one I
30 referred to this morning when I was giving
31 examples, so I did leave it out in sequence.

32 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

12:29:26 1 didn't give it' after [resident]
12:29:29 2 insisted that she hadn't had
12:29:31 3 it."

12:29:31 4 Do you see that document?

12:29:32 5 A. Yes.

12:29:34 6 Q. All right. It goes on to say
12:29:41 7 that the blood sugar of the resident was 17.2
12:29:46 8 that night.

12:29:47 9 Now, if insulin isn't given to a
12:29:50 10 diabetic, what happens with the blood sugars?

12:29:53 11 A. The blood sugar rises.

12:29:55 12 Q. All right. And are you able
12:29:57 13 to comment in your experience on whether 17.2
12:30:01 14 is normal blood sugar, high, low?

12:30:04 15 A. It is quite high. This
12:30:10 16 resident, you know, had a higher blood sugar
12:30:15 17 than most residents as a rule.

12:30:20 18 Q. And it appears that this
12:30:22 19 resident was capable enough to identify to the
12:30:23 20 nurse herself that she hadn't been given her
12:30:28 21 insulin?

12:30:28 22 A. That's correct.

12:30:29 23 Q. And my understanding from
12:30:32 24 your affidavit is there were actually two
12:30:34 25 medication errors on March the 24th, and the
12:30:41 26 second one is the next document in that tab,
12:30:46 27 document 16908. And this is actually Wayne
12:31:05 28 Hedges. So, Commissioner, we haven't redacted
12:31:08 29 the document because Mr. Hedges is one of the
12:31:12 30 victims.

12:31:12 31 It says:

12:31:15 32 "March 24, 2008."

12:31:20 1 Under "Description":
12:31:22 2 "Notified by Res 3-1 that she,"
12:31:26 3 and we believe that to be an
12:31:26 4 error in terms of gender, "had
12:31:28 5 not received HS insulin.
12:31:31 6 1500-2300 hour RN telephoned at
12:31:35 7 home and confirmed that Wayne's
12:31:37 8 insulin had not been given."
12:31:40 9 Do you see that?
12:31:40 10 A. Yes.
12:31:40 11 Q. And was it your understanding
12:31:42 12 that that RN was Elizabeth Wettlaufer?
12:31:47 13 A. Yes.
12:31:47 14 Q. And what is your
12:31:48 15 understanding as to what happened then on March
12:31:52 16 24th, without using the other resident's name?
12:31:54 17 A. I believe that the RN working
12:32:02 18 the night shift realized that there was another
12:32:06 19 resident on that wing that might not have got
12:32:11 20 his insulin, so she checked his insulin -- or
12:32:15 21 his blood sugar level, rather, and noted that
12:32:20 22 it was high and then called Bethe again to ask
12:32:27 23 her, you know, are you sure that you gave the
12:32:30 24 insulin because the first resident said she
12:32:36 25 didn't have it and now I'm finding this high
12:32:40 26 blood sugar for this resident.
12:32:42 27 Q. All right. And this incident
12:32:46 28 report indicates that Mr. Hedges was "observed
12:32:50 29 throughout shift after [being] given HS
12:32:53 30 insulin," so this would be by the nurse that
12:32:54 31 discovered it?
12:32:55 32 A. Yes.

1 Q. "For blood sugar of over 26,"
2 so would that be high?

3 A. Yes.

4 Q. And it indicates that again
5 this particular resident was capable enough to
6 identify to the nurse on staff at that point in
7 time that he had not been given his insulin?

8 A. I don't know if that is true.
9 I think Lois determined that he didn't have his
10 insulin. You know, I don't know what his
11 condition was at this time.

12 Q. All right, so maybe we have
13 got this wrong. It says notified by resident
14 3-1 that she had not been given her insulin?

15 A. So that was the first one.

16 Q. So that was the first one who
17 was a female resident, okay, thank you very
18 much. Now, the writing on the top right-hand
19 side of this document, whose handwriting is
20 that?

21 A. That is my writing.

22 Q. And what does it say?

23 A. It says that I:

24 "Spoke to Bethe April 7/08 at
25 1607. To remedy this she is
26 taking med cards for insulin and
27 putting on top of med cart. I
28 asked to use the MAR as her
29 Bible signing as you go, and you
30 would realize potential
31 omissions."

32 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.

1 Q. Okay. And was that in
2 substitution of using the Medication
3 Administration Record?

4 A. It was in addition to, and it
5 was a process left over from the carded system
6 that, you know, we didn't really think about at
7 the time, and so I discussed it either with the
8 Nurse Consultant or the Pharmacy Consultant and
9 we got rid of those cards altogether.

10 Q. And what do you understand
11 Ms. Wettlaufer to have done or have not done
12 with this box of cards?

13 A. I believed that she forgot to
14 look or get those cards out and that she didn't
15 put him -- put them on her cart to remind her
16 to give insulin and that she didn't use her MAR
17 at all.

18 Q. So was Elizabeth Wettlaufer
19 then disciplined for this particular incident
20 or these two incidents together?

21 A. No, she was just counselled.

22 Q. Now, while we are talking
23 about counselling, in the sense of the union,
24 are they able to grieve a counselling?

25 A. No.

26 Q. Okay. And so what -- and it
27 is hard to go back. Hindsight is always,
28 unlike me, perfect 20/20 vision, but what would
29 your thinking at this point in time be, if you
30 can recall, as to how these med errors were
31 being dealt with?

32 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 --

12:39:09 1 MS. HEWITT: It won't take very
12:39:10 2 long, so if Helen is up for it,
12:39:13 3 we can do it, but --
12:39:14 4 THE WITNESS: That is fine.
12:39:16 5 BY MS. HEWITT:
12:39:16 6 Q. Are you up for it? Okay.
12:39:19 7 So there is a performance -- let
12:39:24 8 me ask who was responsible, first of all, for
12:39:26 9 Performance Appraisals?
12:39:27 10 A. I was responsible for the
12:39:30 11 Registered Nurses.
12:39:31 12 Q. All right. And that would
12:39:34 13 include, after she was hired, Elizabeth
12:39:38 14 Wettlaufer?
12:39:38 15 A. That's correct.
12:39:38 16 Q. And my understanding from a
12:39:40 17 review of the employment file is that there was
12:39:44 18 an Employee Performance Appraisal in 2008, on
12:39:49 19 December 17th 2008; is that your recollection?
12:39:52 20 A. Yes.
12:39:53 21 Q. So, Commissioner, if we could
12:40:00 22 turn to tab F, which is document number 16903.
12:40:21 23 Whose handwriting is on this first page, Helen?
12:40:26 24 A. That is my handwriting.
12:40:27 25 Q. So I want to scroll first,
12:40:30 26 Amanda, to page number 4.
12:40:32 27 My understanding, Helen, is you
12:40:35 28 used a system of numerical rating of 1 to 4?
12:40:39 29 A. That's correct.
12:40:40 30 Q. And I just wanted to show
12:40:43 31 what that rating meant. So 4 was good, it was
12:40:47 32 commendable?

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A. Yes.

Q. And then competent at 3, provisional at 2, and poor at 1?

A. Yes.

Q. And those are the definitions that you would work with at the time?

A. Yes.

Q. All right. So if we can go back to page number 1, Amanda, please.

So in terms of your process, what would you look at in order to form the opinion that you refer in the Performance Appraisals? What would be your process?

A. Well, I used to ask for other nurses' opinions. I don't know if I did it in 2013. I don't think I did. I think I just, you know, talked with the other managers and if they had any concerns, you know, I would jot that down.

Q. And we saw in the earlier remarks that I made in the Commission that Christian Horizons had a Performance Appraisal process that allowed for a 360 review; in other words, peers reviewed others. Did you ever have a 360 review process or anything like that within Caressant Care?

A. Well, we did -- I did that in the beginning when the nurses weren't quite as busy and I would, you know, just write out everybody's name and pass out the form to the RNs and ask them for a few comments on each of their co-workers.

1 Q. Would they all be on one
2 sheet or would they be separate sheets?

3 A. They would be separate sheets
4 for each RN I was asking.

5 Q. All right. And then did that
6 process -- you said you "used to," did that
7 process drop off?

8 A. Yes. The Registered Nurses
9 felt they were too busy and didn't want to take
10 part in the process.

11 Q. And you didn't have any
12 corporate policy or home-based actual written
13 policy for those types of reviews?

14 A. Not that I am aware, no.

15 Q. For 360 reviews, okay.
16 And just to go through a couple
17 of things on your appraisal of Elizabeth
18 Wettlaufer, and this is into her first year and
19 a half. Under "Medication administration
20 skills," it says the "Appraisers rating"; is
21 that you?

22 A. Yes.

23 Q. And it says 2.5, and I'll
24 flip for you so nobody has to, 2 is provisional
25 and 3 is competent, and so you were giving her
26 a mid-mark on medication administration?

27 A. Yes.

28 Q. And then it says "Staff
29 rating." Do they actually give themselves a
30 rating as well?

31 A. Yes, they would get the form
32 first and rate themselves first, and then I

12:43:51 1 would rate them. And then we would get
12:43:52 2 together and decide on the agreed rating.
12:43:55 3 Q. All right. So at that point
12:43:57 4 in time the rating stayed at 2.5?
12:44:00 5 A. Yes.
12:44:01 6 Q. And what did that mean to you
12:44:03 7 in terms of rating somebody 2.5 on medication
12:44:07 8 administration skills?
12:44:08 9 A. That she needed to improve.
12:44:09 10 Q. Okay. Under the second one
12:44:12 11 it says "Knows residents well," but I'll go to
12:44:17 12 the fourth bullet point there, "Effective
12:44:20 13 supervision of others." She actually gave
12:44:22 14 herself a 2, if I'm reading this form right; is
12:44:27 15 that correct?
12:44:27 16 A. I think I did that writing.
12:44:30 17 I think maybe she didn't fill it out, and --
12:44:34 18 because that is my writing as well. So I would
12:44:37 19 ask her, what would you give yourself for
12:44:39 20 medication administration, what would you give
12:44:41 21 yourself for effective supervision of others.
12:44:43 22 Q. But she is telling you she
12:44:46 23 would actually rate herself as a 2?
12:44:47 24 A. Yes.
12:44:48 25 Q. And you are writing it down?
12:44:49 26 A. Yes.
12:44:50 27 Q. And on the right-hand side it
12:44:53 28 says, if I'm reading your handwriting right, it
12:44:55 29 says "was friendly (too)" and that is a symbol
12:45:01 30 for "[with] PSWs"?
12:45:03 31 A. Yes.
12:45:03 32 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?

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12:47:59 26
12:48:02 27
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12:48:09 30
12:48:11 31
12:48:14 32

A. Yes.

Q. And can you describe how she was with the residents while she was at Caressant Care?

A. Usually when I saw her, she was interactive with residents, friendly, but she did have, you know, a couple of issues, and I don't know if it was before or after this time, with a couple of residents.

Q. Thank you. Anything in terms of her interactions with the residents that would have caused you alarm over the years?

A. Not so much alarm as -- you know, the one in particular, it was in the morning, that I recall and, you know, it was after working a night shift and I thought she was, you know, tired and not so under control.

Q. Sorry, is that something that is referred to in your affidavit?

A. Yes.

Q. Okay, we'll get to that, so you don't have to.

So we'll just finish this off, and then it would probably be an appropriate time for the break. Under "Areas of proficiency," you say "Team conference summary is well done", and "teaching small e's" -- does that say "teaching small 'e's and summer students"?

A. These were students, our high school students that would come in after 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.

1 Q. And what you are referring to
2 is the next -- what we'll see as the next
3 Performance Appraisal in her file was not until
4 2013; is that correct?

5 A. That's correct.

6 Q. And your recollection would
7 be there were more but they simply cannot be
8 located?

9 A. Yes.

10 Q. All right. I think that is
11 an appropriate time for a break, Commissioner?

12 THE COMMISSIONER: All right,
13 thank you.

14 And so just to make sure that I
15 am clear, today we are going to
16 stay with our one-hour for the
17 lunch recess; is that correct?

18 MS. HEWITT: That's correct.

19 THE COMMISSIONER: Thank you.

20 -- RECESSED AT 12:51 P.M.

21 -- RESUMED AT 1:52 P.M.

22 THE COMMISSIONER: Just before
23 you get going, Ms. Hewitt, they
24 want to clean the courtroom over
25 the weekend. I don't know if
26 people were thinking that they
27 were going to leave anything in
28 the room. Is there a problem if
29 we clean everything out? I
30 don't think -- so because at
31 nights we are keeping it all
32 locked and not letting in

13:53:46 1 cleaning staff or anything else,
13:53:47 2 but they should clean once a
13:53:49 3 week.

13:53:49 4 So unless that is a problem, I'm
13:53:52 5 just going to say go ahead, and
13:53:53 6 everybody will have, including
13:53:54 7 me, have all our documents out
13:53:55 8 of here.

13:53:57 9 MS. HEWITT: Thank you,
13:53:58 10 Commissioner.

13:54:07 11 THE COMMISSIONER: Go ahead,
13:54:08 12 when you are ready.

13:54:09 13 BY MS. HEWITT:

13:54:09 14 Q. Thank you very much,
13:54:10 15 Commissioner.

13:54:10 16 Good afternoon again, Helen.

13:54:12 17 I just want to clean up a few
13:54:14 18 things there, and thank you to Mr. Sandler for
13:54:19 19 bringing this to my attention. There is just a
13:54:22 20 couple of other documents in 2007 and 2008 that
13:54:26 21 I wanted to review, and it is all leading up to
13:54:28 22 your December 2008 Performance Appraisal, but
13:54:32 23 just for the completeness of everything, I'll
13:54:34 24 take you to them.

13:54:35 25 The first is actually -- it is
13:54:38 26 not in your affidavit. It is document 16918.
13:54:42 27 It is in the Overview Report at Exhibit 6,
13:54:49 28 Volume 5, Commissioner.

13:54:50 29 And, Amanda, the next one I'll
13:54:55 30 be going to is 16917.

13:55:07 31 So you have to read this on your
13:55:10 32 screen, Helen.

13:55:10 1 A. Okay.

13:55:12 2 Q. And this purports to be an

13:55:38 3 email from Marie Buckrell to yourself, and just

13:55:49 4 take your time and just read through that for a

13:55:52 5 moment with me, or yourself.

13:55:55 6 A. (Witness reviews document.)

13:55:55 7 MS. STRATTON: Is that too big?

13:56:02 8 BY MS. HEWITT:

13:56:02 9 Q. That is too big. That is too

13:56:04 10 small.

13:56:04 11 Just let me know when you have

13:56:11 12 had an opportunity, Helen.

13:56:14 13 A. (Witness reviews document.)

13:56:50 14 Q. And my question, first of

13:56:51 15 all, is if you have any independent

13:56:54 16 recollection of this issue?

13:56:55 17 A. No, I don't.

13:56:56 18 Q. And do you know what it is

13:56:57 19 referring to, what type of incident is referred

13:56:59 20 to on this email?

13:57:15 21 MS. HEWITT: Commissioner, it

13:57:17 22 looks like we might have some

13:57:18 23 technological difficulties.

13:57:20 24 COURT SERVICES OFFICER: We are

13:57:23 25 getting some feedback, and I am

13:57:25 26 not sure from where. If we

13:57:36 27 could get some IT assistance,

13:57:40 28 Your Honour.

13:57:43 29 BY MS. HEWITT:

13:57:43 30 Q. Is that going to be

13:57:44 31 distracting to you, Helen?

13:57:46 32 A. Well, it is, you know, hard

13:57:47 1 to hear, so I think we'll need to speak louder.

13:57:57 2 I believe Bethe went home and
13:58:00 3 had signed for medications that she didn't
13:58:02 4 give.

13:58:03 5 Q. Would that be a medication
13:58:05 6 error?

13:58:05 7 A. Yes.

13:58:06 8 Q. And the other issue talks
13:58:08 9 about 3:00 to 11:00 staff who were sitting --
13:58:23 10 magic.

13:58:24 11 THE COMMISSIONER: Turn it down.

13:58:26 12 THE WITNESS: He just put his
13:58:28 13 hand in front of it.

13:58:30 14 BY MS. HEWITT:

13:58:31 15 Q. The other item on the bottom
13:58:34 16 is:

13:58:34 17 "3 to 11 staff who were sitting
13:58:37 18 in the dining room at 2215 while
13:58:40 19 three bells were ringing - Sue
13:58:42 20 had asked them to answer bells
13:58:43 21 more than once before 2300. She
13:58:45 22 asked them about rounds and was
13:58:47 23 told they where starting soon.
13:58:51 24 While she was giving meds, she
13:58:52 25 noted they did go in and out of
13:58:54 26 some rooms, but feels rounds
13:58:56 27 were not done well."

13:58:59 28 So do you recall any of this
13:59:00 29 being brought to your attention at the time?

13:59:02 30 A. I don't recall it, no.

13:59:04 31 Q. All right. If we can go to
13:59:06 32 document 16917 and this indicates it is an

1 investigative meeting with Bethe Wettlaufer and
2 in attendance there are Bethe Wettlaufer,
3 Mirian Wright. So what would Mirian's role be
4 there?

5 A. It looks like she was either
6 the union rep.

7 Q. All right. And if we just go
8 down to the second paragraph, it indicates:

9 "Beth did not deny that she
10 indeed did not give out [the
11 Resident] medication, and
12 realized immediately that she
13 had made an error. Beth also
14 signed for another room that had
15 not received their pills. Beth
16 said that she signs for the
17 pills, pours them and then goes
18 into the room with the
19 medication. She was apparently
20 doing this just this when Sue
21 Kungl came in, and Beth did not
22 finish what she was doing. When
23 asked how she could avoid this
24 in the future, Beth said that
25 she would leave a note to
26 herself on top of the medication
27 cart. Mrs. Crombez told Beth
28 that she must change her
29 procedure to signing after
30 giving the medication.
31 Mrs. Crombez also brought up
32 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

14:01:42 1 there was no discipline given, there was still
14:01:44 2 union representation for Ms. Wettlaufer in that
14:01:46 3 meeting?

14:01:47 4 A. That's correct.

14:01:47 5 Q. Thank you. Now, if we go
14:01:54 6 back to your exhibit at Exhibit No. II and that
14:02:06 7 is document number 16907 and this is a
14:02:32 8 Medication Incident Report. We have seen a
14:02:34 9 couple of these reports before.

14:02:37 10 Now, you indicated in your
14:02:39 11 affidavit that you didn't have any independent
14:02:42 12 recollection of this particular issue, but just
14:02:45 13 for the record, we'll identify it, in any
14:02:47 14 event.

14:02:48 15 It is an incident that purports
14:02:53 16 to, if I'm reading this right, have occurred on
14:02:55 17 June 22nd at 2000 hours; is that correct?

14:02:59 18 A. That's correct.

14:03:00 19 Q. And the brief description of
14:03:01 20 the incident is:

14:03:05 21 "20.00 hydromorph Contin 3 mg.
14:03:11 22 not given by BW [...]"

14:03:13 23 Which would you understand that
14:03:15 24 to be Bethe Wettlaufer?

14:03:18 25 A. That's correct.

14:03:19 26 "[...] RN, still in card at
14:03:21 27 0800 med pass on Monday."

14:03:25 28 Is that correct?

14:03:25 29 A. Yes.

14:03:25 30 Q. Now, you say that you had no
14:03:28 31 independent recollection of this. The writing
14:03:32 32 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 1 A. No, not any formal training.

14:05:00 2 Q. All right. So how did you
14:05:02 3 learn how to perform the investigations that
14:05:06 4 you were doing during your career as Director
14:05:09 5 of Nursing?

14:05:09 6 A. Well, usually by mistake, I
14:05:18 7 think. We would investigate and perhaps give a
14:05:21 8 grievance or give a discipline, and then it
14:05:26 9 would be grieved and it wouldn't go anywhere or
14:05:32 10 be, you know, dropped back or rescinded. And
14:05:38 11 so it was kind of learn as you go.

14:05:40 12 Q. Now, we have heard about one
14:05:44 13 union that you were dealing with at Caressant
14:05:46 14 Care and that is ONA. Were there any other
14:05:49 15 unionized employees at Caressant Care?

14:05:52 16 A. Yes, there was, when I first
14:05:53 17 started it was CLAC, and then it became CAW,
14:05:57 18 and then it became Unifor.

14:06:00 19 Q. So CLAC is the acronym
14:06:04 20 C-L-A-C?

14:06:05 21 A. Yes, Christian Labour
14:06:07 22 Association something of Canada.

14:06:10 23 Q. And who was that organization
14:06:12 24 the union for?

14:06:13 25 A. For the PSWs and the RPNs.

14:06:22 26 Q. And at some point in time did
14:06:22 27 ONA take over the RPNs?

14:06:24 28 A. No.

14:06:24 29 Q. No? So it just remained
14:06:28 30 CLAC?

14:06:28 31 A. Yeah.

14:06:29 32 Q. All right. And was that the

14:06:34 1 same at the end of the day when you left
14:06:35 2 Caressant Care?

14:06:35 3 A. I believe so, yes.

14:06:36 4 Q. So when you are talking to us
14:06:38 5 about you would get a discipline and it would
14:06:40 6 be grieved, are you talking about solely issues
14:06:43 7 with ONA or was it those issues as well with
14:06:47 8 the other union?

14:06:47 9 A. They were more with the other
14:06:49 10 union.

14:06:50 11 Q. So that is where you learned
14:06:52 12 in terms of grievances and documentation, okay.

14:07:00 13 Now, I just want to take you
14:07:04 14 briefly through the absenteeism issue that is
14:07:08 15 found at -- it starts at paragraph 90 of your
14:07:15 16 affidavit. And if I can turn us first -- that
14:07:20 17 is Exhibit No. 8, Commissioner.

14:07:21 18 And I'm going to start with the
14:07:30 19 first one that had a verbal warning, which is
14:07:33 20 July 7th, 2010. I don't want to take you to
14:07:37 21 the letter. It was a verbal warning. It is
14:07:40 22 already in evidence, and Ms. Van Quaethem
14:07:43 23 reviewed it.

14:07:44 24 But I do want take you to
14:07:46 25 document 16884, which is the second -- I
14:07:58 26 believe it is the fourth document in. It is a
14:07:59 27 set of handwritten notes, Commissioner.

14:08:02 28 THE COMMISSIONER: Yes, thank
14:08:02 29 you.

14:08:03 30 BY MS. HEWITT:

14:08:05 31 Q. Do you recognize this
14:08:06 32 handwriting?

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A. This is Marie Buckrell's writing.

Q. All right. And is this a meeting at which you were present?

A. Yes, I believe I was talking.

Q. And who else --

A. And Marie was documenting, sorry.

Q. So it would be yourself, Marie Buckrell, it says Karen R., and who would Karen R. be?

A. Karen Routledge and she was the ONA rep, I believe.

Q. And it indicates a third of the way down the page:

"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."

So in terms of this, was it an incident where she had called in shortly before her shift was due?

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.

Q. And when what happens, what effect does that have in the home, if you have got an RN calling in just before shift?

A. Well, there aren't a lot of options, you know, that late in the day, so we

14:09:36 1 would probably have asked one of the other RNs
14:09:38 2 in the building if they could stay, you know,
14:09:41 3 until we found coverage. And if we weren't
14:09:46 4 successful, then we would ask the night RN to
14:09:49 5 come in early to try and cover that.

14:09:50 6 Q. All right. And it goes on to
14:09:53 7 say:

14:09:54 8 "Bethe stated 'I only call in
14:09:57 9 sick when I am sick and the
14:09:59 10 personal days can't be helped.'"
14:10:02 11 So that is Ms. Wettlaufer
14:10:04 12 speaking?

14:10:04 13 A. Yes.

14:10:04 14 Q. And then:

14:10:06 15 "We are giving you a verbal
14:10:07 16 warning for the above. We did
14:10:08 17 discuss the expectations when
14:10:09 18 you took this full time line.
14:10:11 19 Bethe wanted to know if she was
14:10:12 20 not allowed to have a sick day?"
14:10:15 21 So that is the outcome of that
14:10:16 22 particular meeting?

14:10:17 23 A. Yes.

14:10:17 24 Q. All right. And if I can
14:10:22 25 quickly take you then to document 16870. This
14:10:43 26 is again a Disciplinary Action Form dated March
14:10:46 27 31st, 2011?

14:10:48 28 A. Yes.

14:10:48 29 Q. And does it identify the type
14:10:50 30 of discipline that Elizabeth Wettlaufer was
14:10:54 31 being given?

14:10:55 32 A. She received a:

14:10:57 1 "Written warning with notice
14:10:59 2 that continuing absenteeism will
14:11:02 3 result in disciplinary action up
14:11:03 4 to and including termination."

14:11:08 5 Q. And Ms. Routledge signs as
14:11:09 6 the union rep?

14:11:11 7 A. Yes.

14:11:11 8 Q. And under "Additional
14:11:12 9 information" it identifies:

14:11:15 10 "Management requires you to
14:11:16 11 bring in a Doctor's note from
14:11:18 12 now on dated the day of your
14:11:19 13 illness."

14:11:20 14 What does that refer to?

14:11:22 15 A. Well, we were asking her to
14:11:24 16 bring in a doctor's note when she was ill the
14:11:30 17 day of her illness to try and make her more
14:11:36 18 accountable.

14:11:37 19 Q. Thank you. And then document
14:11:41 20 16867, and is this a second written warning
14:12:01 21 that you are providing Elizabeth Wettlaufer?

14:12:04 22 A. That's correct.

14:12:04 23 Q. And you note on the bottom
14:12:08 24 right-hand side:

14:12:10 25 "First Written Warning March 31,
14:12:14 26 2011. Must bring a doctor's
14:12:16 27 note for illness [...]"

14:12:18 28 Is that correct?

14:12:18 29 A. That's correct.

14:12:19 30 Q. And you are referring to the
14:12:20 31 previous document?

14:12:21 32 A. That's correct.

1 Q. And it identifies under
2 "Union rep," is that scratched out and
3 "Witness"?

4 A. That's correct.

5 Q. And do you know who that was?

6 A. That was Jennifer Hague.

7 Q. All right. If I can take you
8 to document 16858. And this is dated August
9 26, 2011?

10 A. Yes.

11 Q. And what is the discipline on
12 this particular occasion?

13 A. This is a:

14 "1 day suspension on paper with
15 notice that continuing
16 absenteeism will result in
17 disciplinary action up to and
18 including termination."

19 Q. And did Ms. Wettlaufer have
20 union representation?

21 A. She did. She had Karen
22 Routledge.

23 Q. And then finally, January
24 18th, 2011, document 16818. Do you see that?

25 A. Yes, I do.

26 Q. Now, this document is signed
27 by Ms. Van Quaethem. Would you have seen this
28 document at the time that she would have been
29 delivering it to Ms. Wettlaufer?

30 A. I believe I was probably a
31 witness to this, this happening. We started an
32 attendance management program, I believe, and

14:14:10 1 Brenda averaged out the absenteeism days per
14:14:17 2 the previous year for all staff, and I believe
14:14:20 3 it was six or so.

14:14:24 4 Q. The average, you mean?

14:14:26 5 A. The average, yes, and, you
14:14:30 6 know, she was way above that, and so we gave
14:14:37 7 her a letter.

14:14:38 8 Q. All right, thank you. And at
14:14:39 9 the bottom it says it is copied to the union.
14:14:42 10 Do you have any reason to believe that the
14:14:45 11 union didn't receive a copy of this letter?

14:14:47 12 A. No, I have no reason not to
14:14:51 13 believe this.

14:14:52 14 Q. All right. So if we can then
14:14:55 15 turn to the issues of disputes that Ms.
14:15:01 16 Wettlaufer may have had with her co-workers,
14:15:05 17 can you tell me generally how she got along
14:15:08 18 with her co-workers and what was your
14:15:10 19 impression of the type of disputes that were
14:15:13 20 arising with her?

14:15:14 21 A. Well, she got along with, you
14:15:25 22 know, some of the staff very well, but there
14:15:30 23 were certainly complaints about her behaviour
14:15:35 24 with other staff.

14:15:35 25 Q. All right, and did you deal
14:15:37 26 with her from time to time on those issues?

14:15:40 27 A. Yes.

14:15:40 28 Q. In paragraph 92 of your
14:15:44 29 affidavit, and I will just read it, Amanda, you
14:15:48 30 don't need to go there said:

14:15:50 31 "One of the big issues with
14:15:52 32 Elizabeth Wettlaufer was more

14:15:53 1 her comments about her sexual
14:15:55 2 orientation and being too
14:15:56 3 friendly with the students,
14:15:57 4 inviting them to have pizza with
14:15:59 5 her or inviting them to her home
14:16:01 6 and the way she talked about her
14:16:03 7 partners."

14:16:04 8 Was that one of the issues that
14:16:06 9 you would have been dealing with with Elizabeth
14:16:08 10 Wettlaufer.

14:16:08 11 A. That's correct.

14:16:09 12 Q. If I can turn you to document
14:16:23 13 number 16898. You have had an opportunity to
14:16:36 14 review this document, Helen?

14:16:38 15 A. I have.

14:16:39 16 Q. All right, and in respect of
14:16:42 17 this document, and I won't take you to all of
14:16:46 18 the documents, but there are a number of
14:16:50 19 documents indicating an investigatory meeting
14:16:56 20 with yourself -- sorry, with Marie Buckrell,
14:16:59 21 Bethe Wettlaufer, Brenda and Karen Routledge,
14:17:02 22 but in general when you reviewed this, what was
14:17:03 23 your view of the situation that was occurring
14:17:05 24 at the time?

14:17:06 25 A. Well, I believe the
14:17:13 26 complainant was Libby, and I thought that she
14:17:18 27 was a very nice person and a good nurse, so I
14:17:31 28 was upset that, you know, there was trouble
14:17:35 29 amongst the registered staff. They are
14:17:39 30 supposed to be professional and be a cut above,
14:17:43 31 if you will, and this was, you know, poor
14:17:48 32 behaviour.

14:17:49 1 Q. All right. Now, we'll leave
14:17:51 2 that because we did canvass that in detail
14:17:53 3 yesterday with Ms. Van Quaethem.

14:17:55 4 If I can take you to the
14:18:01 5 incident on January 19th, and this is document
14:18:08 6 16888 found, sorry, Commissioner, at tab K,
14:18:16 7 Exhibit K. And I won't read this back into the
14:18:31 8 record, because I read it yesterday, Helen, but
14:18:32 9 it identifies that there was an issue on shift
14:18:34 10 between Bethe Wettlaufer and another RN when
14:18:39 11 the other RN was using the residents' last
14:18:42 12 names. Do you recall this incident?

14:18:45 13 A. Yes, I do.

14:18:46 14 Q. And what was your view as the
14:18:48 15 Director of Nursing as to what was taking place
14:18:50 16 here between Elizabeth Wettlaufer and this
14:18:53 17 other nurse?

14:18:55 18 A. Well, I did feel that Bethe
14:19:00 19 had a point, you know. I respected the
14:19:03 20 residents and I like people to call them by
14:19:05 21 their full name or use "Mr." and "Mrs." so in
14:19:10 22 that respect I thought Bethe was echoing, you
14:19:13 23 know, what I felt myself.

14:19:15 24 Q. And then this particular
14:19:19 25 situation goes on to say that there was -- Ms.
14:19:25 26 Wettlaufer showed this particular nurse her
14:19:27 27 boil, and what the nurse says is:

14:19:30 28 "Before I could respond, she
14:19:31 29 pulled down the right side of
14:19:33 30 her uniform bottom so she would
14:19:35 31 show it to me. I am sure she is
14:19:36 32 not aware that she was exposing

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14:19:53 5
14:19:55 6
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14:20:17 10
14:20:19 11
14:20:25 12
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part of her groin."
What about that particular
situation in terms of Ms. Wettlaufer?
A. Well, it wasn't appropriate,
and I also thought, you know, going back to the
first part of the complaint, that Bethe could
have handled it better than, you know, being
kind of abrupt about it or rude about it.
Q. And the documentation, you
don't have to pull it up, Amanda, because we
did go through it yesterday, at 16890 indicates
that you had a meeting with Elizabeth
Wettlaufer and Karen Routledge and Brenda?
A. Yes.
Q. And what was the outcome of
this particular issue?
A. Can you refer me to the
document? Do we have it?
Q. Yes, we can go to the
document or -- it is 16890. I think your
affidavit identifies that this particular
incident resulted in counselling.
A. Is it in my document?
Q. Yes, it is at tab K, the last
document at tab K.
A. Tab, sorry, which?
Q. Tab K.
A. K?
THE COURT CLERK: It is 16890.
THE WITNESS: Yes. This was
just a counselling, I think.
BY MS. HEWITT:

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

10 A. Yes, uhm-hmm.

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

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

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

23 A. That's correct.

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

27 A. This is my handwriting.

28 Q. And it indicates:

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

14:23:34 1 workplace."

14:23:36 2 A. That's correct.

14:23:36 3 Q. And then down two lines:

14:23:38 4 "It could be the fact that I am

14:23:40 5 a lesbian."

14:23:42 6 Do you recall her using that

14:23:44 7 particular situation to explain what was

14:23:46 8 happening or why there were complaints being

14:23:49 9 given?

14:23:49 10 A. Yes, I do.

14:23:50 11 Q. And was that on this one

14:23:53 12 occasion? Was that on more than one occasion?

14:23:58 13 Or do you recall?

14:23:59 14 A. I know it happened this time.

14:24:04 15 I don't know -- I can't recall that it happened

14:24:06 16 another time.

14:24:06 17 Q. All right.

14:24:08 18 A. Off the top of my head.

14:24:10 19 Q. And your affidavit indicates

14:24:12 20 that she was given counselling for this

14:24:14 21 particular situation; is that correct?

14:24:16 22 A. That's correct.

14:24:17 23 Q. Okay. I do want to take some

14:24:26 24 time to go through a document we only briefly

14:24:30 25 touched on with Ms. Van Quaethem the other day,

14:24:34 26 and that is document 16841 and it is an email

14:24:38 27 that is addressed to you and copied to Brenda

14:24:42 28 Van Quaethem.

14:24:43 29 Do you recall this particular

14:24:54 30 email, Helen?

14:24:55 31 A. Yes, I do.

14:24:59 32 Q. And --

14:25:01 1 A. Well, I don't recall it, but
14:25:03 2 I know it happened, yes.

14:25:04 3 Q. And I read it all into -- I
14:25:07 4 believe I read it into the record yesterday, so
14:25:11 5 I won't do that again. But the first paragraph
14:25:13 6 of that is talking about the narcotic counts
14:25:16 7 and when they are done and who is doing it; is
14:25:19 8 that correct?

14:25:19 9 A. Yes.

14:25:20 10 Q. So can you explain to us,
14:25:22 11 first of all, in respect of that issue, this
14:25:28 12 particular employee at the very end of that
14:25:30 13 first paragraph says:

14:25:34 14 "[...] I was in the lounge and
14:25:35 15 you should have called my name.
14:25:36 16 Now I thought it was the time to
14:25:38 17 speak up and made it very clear
14:25:39 18 to her that I will not be coming
14:25:42 19 for count anymore and it is not
14:25:43 20 my job. Moreover, I was not
14:25:46 21 sure if the ministry and
14:25:48 22 management will accept this
14:25:49 23 arrangement."

14:25:52 24 Do you know what he is talking
14:25:53 25 about in that particular paragraph?

14:25:56 26 A. Well, I think it is, you
14:25:57 27 know, a bit of an understatement, because, you
14:26:02 28 know, when we organized the narcotic count, it
14:26:04 29 was supposed to be at change of shift. So
14:26:10 30 doing it at 4:30, there are still medications
14:26:14 31 that the night nurse gives at 6:00, and if
14:26:19 32 someone asks for a narcotic medication, how can

14:26:25 1 you count accurately if that is to happen yet?

14:26:29 2 Q. And is this particular
14:26:32 3 employee an RN or an RPN?

14:26:34 4 A. I believe he was trained as
14:26:40 5 an RN in India but he was working for us as an
14:26:44 6 RPN.

14:26:45 7 Q. And so if we look at the time
14:26:47 8 that this is taking place, and that is 0430,
14:26:50 9 and that would be the night shift; correct?

14:26:52 10 A. That's correct.

14:26:53 11 Q. And so if I recall our
14:26:55 12 discussion earlier this morning about shifts,
14:26:58 13 on the night shift at Caressant Care would be
14:27:01 14 one Registered Nurse and one Registered
14:27:05 15 Practical Nurse?

14:27:05 16 A. That's correct.

14:27:05 17 Q. And Bethe Wettlaufer would be
14:27:08 18 the nurse in charge; is that correct?

14:27:10 19 A. That's correct.

14:27:11 20 Q. And in this particular
14:27:14 21 situation, he is working in the other part --
14:27:19 22 she is in Section B and he is working in the
14:27:21 23 other part?

14:27:21 24 A. That's correct.

14:27:22 25 Q. And he is identifying he is
14:27:24 26 having to come over and do narcotic count?

14:27:26 27 A. Yes.

14:27:27 28 Q. And so I thought that the
14:27:28 29 process was that the on-coming shift does
14:27:31 30 narcotic count?

14:27:32 31 A. Yes.

14:27:32 32 Q. So was this -- the way that

14:27:36 1 this was taking place, not to mention the
14:27:39 2 timing, but the way they were doing it, was it
14:27:43 3 accurate?

14:27:44 4 A. It was a shock to me.

14:27:46 5 Q. All right. So do you recall
14:27:48 6 whether it did shock you? It was emailed to
14:27:52 7 you.

14:27:52 8 A. Yes, I dealt with it,
14:27:53 9 actually. I reviewed the process with all the
14:27:58 10 staff. I don't know if I typed out a memo or
14:28:04 11 wrote it in the communication books in each --
14:28:10 12 sometimes I would type it out and then copy it
14:28:13 13 three times and take it to each communication
14:28:15 14 book, and I talked, you know, to the staff
14:28:18 15 one-to-one when I saw them and I said, you
14:28:20 16 know, this has to change.

14:28:23 17 Q. Was it more than Bethe
14:28:25 18 Wettlaufer that was doing it this way?

14:28:26 19 A. I don't believe so, but it
14:28:30 20 wasn't right and it, you know, had to change
14:28:32 21 immediately.

14:28:34 22 Q. Was there any explanation
14:28:36 23 given as to why this particular practice had
14:28:38 24 developed in the home at night?

14:28:39 25 A. I can't recall.

14:28:43 26 Q. All right. And so that is
14:28:45 27 how you dealt with this situation from the
14:28:48 28 employee?

14:28:49 29 A. Yes.

14:28:50 30 Q. Now, on the bottom it says:
14:28:52 31 "Manju emailed and did not want
14:28:56 32 action taken."

14:28:58 1 That is not your handwriting, is
14:29:00 2 it?

14:29:00 3 A. No, that is Brenda's
14:29:01 4 handwriting.

14:29:01 5 Q. And do you understand what
14:29:03 6 was meant by that?

14:29:04 7 A. Well, I believe Manju didn't
14:29:07 8 want Bethe to know that he had complained about
14:29:10 9 her, so that is how I handled the situation.

14:29:18 10 Q. All right, thank you. Now,
14:29:23 11 in terms of Ms. Wettlaufer's work performance,
14:29:30 12 how did you generally find her as a nurse?

14:29:33 13 A. Well, she -- whenever I saw
14:29:41 14 her in the hallway, she seemed to be
14:29:45 15 interacting well, you know, with the residents.
14:29:52 16 She was, you know, pleasant and polite. She
14:29:57 17 would ask how my day was going. You know, she
14:30:02 18 would talk to me about particular residents.
14:30:05 19 If I had had a concern about someone, she would
14:30:11 20 say oh, you know, I think there -- or she told
14:30:17 21 me so-and-so seems to be over the hump; she has
14:30:24 22 been on, you know, the antibiotic for three
14:30:28 23 days, four days, and I fed her supper, and, you
14:30:31 24 know, she ate pretty well.

14:30:35 25 Q. Well, let's go through some
14:30:37 26 of the issues that may have developed over the
14:30:39 27 years, and I will turn you to document 16886.
14:31:01 28 And that is a letter dated February 27th, 2009,
14:31:05 29 and, as I understand it, this pre-dates Ms. Van
14:31:09 30 Quaethem's coming to Caressant Care; is that
14:31:11 31 correct?

14:31:11 32 A. That's correct.

14:31:11 1 Q. And you signed this letter as
14:31:14 2 Director of Nursing?

14:31:15 3 A. Yes.

14:31:19 4 Q. And it indicates:

14:31:20 5 "Items discussed were eating at
14:31:23 6 the desk, taking and eating
14:31:24 7 nursing home food, leaving the
14:31:26 8 building on your break and not
14:31:27 9 following through with your
14:31:28 10 nursing duties."

14:31:30 11 Now, the only thing that so far
14:31:33 12 we were able to locate is this letter.

14:31:35 13 A. Uhm-hmm.

14:31:35 14 Q. Do you recall this situation
14:31:38 15 at all?

14:31:39 16 A. No, I don't recall.

14:31:43 17 Q. Okay. Did you have a concern
14:31:48 18 about her leaving the building on her break?

14:31:51 19 A. I certainly did.

14:31:52 20 Q. What would that concern be?

14:31:54 21 A. Well, if -- you know, she was
14:31:59 22 the Charge Nurse. What if, you know, a fire
14:32:02 23 had started, and, you know, she was supposed to
14:32:04 24 lead, you know, the fire plan, the evacuation,
14:32:11 25 you know, calling the fire department, that
14:32:13 26 kind of thing.

14:32:13 27 Q. Okay. And taking and eating
14:32:17 28 nursing home food, does that mean she is taking
14:32:19 29 and eating food that the residents would
14:32:21 30 normally eat?

14:32:23 31 A. That's correct.

14:32:23 32 Q. Do you know -- so you have no

14:32:25 1 recollection as to how these issues were
14:32:27 2 brought to your attention?
14:32:28 3 A. No.
14:32:29 4 Q. And no recollection of "not
14:32:31 5 following through on your nursing duties," what
14:32:37 6 that means?
14:32:38 7 A. No.
14:32:38 8 Q. All right, that is fine.
14:32:45 9 Sorry, Commissioner, I'm going too fast, and I
14:32:48 10 didn't give you that number. It is number "O."
14:32:51 11 THE COMMISSIONER: Thank you.
14:32:51 12 BY MS. HEWITT:
14:32:53 13 Q. So if I can turn to tab P,
14:32:57 14 which is document number 16877. Can you
14:33:20 15 identify the handwriting on this particular
14:33:22 16 note?
14:33:22 17 A. Yes, that was Marie Buckrell.
14:33:25 18 Q. And present is yourself,
14:33:29 19 Karen Routledge and Elizabeth Wettlaufer and
14:33:33 20 Marie Buckrell?
14:33:34 21 A. That's correct.
14:33:36 22 Q. Now, we asked Brenda
14:33:40 23 yesterday about this, but she thought -- she
14:33:43 24 deferred, I believe, to you because it is
14:33:49 25 nursing issues. So it indicates on this letter
14:33:50 26 that there were no treatments done on Level 2?
14:33:56 27 A. Yes.
14:33:57 28 Q. And there is an issue at the
14:34:00 29 bottom of the page:
14:34:01 30 "Your RIA/MDS assignments, you
14:34:05 31 scored 0 out of 105."
14:34:09 32 So can you just expand with us

14:34:11 1 what the issues were that you were dealing with
14:34:13 2 in February 2011?

14:34:14 3 A. She -- well, somehow we knew
14:34:23 4 that she didn't do treatments, whether, you
14:34:25 5 know, some residents complained or she didn't
14:34:30 6 sign for them, or she didn't sign, that is what
14:34:33 7 it says. And I think a resident complained
14:34:41 8 that she didn't have a treatment, and I told
14:34:47 9 her that treatments were just as important as
14:34:50 10 medications.

14:34:52 11 And then she says that she just
14:34:55 12 gave out the prescription creams, and I told
14:34:57 13 her we were giving her a verbal warning.

14:35:00 14 Q. And what did she say?

14:35:02 15 A. "That is fair."

14:35:06 16 Q. Now, just for our benefit,
14:35:07 17 what type of treatments would be being done by
14:35:10 18 the registered staff?

14:35:11 19 A. Well, it would be treatments
14:35:15 20 of a skin laceration or -- what else could it
14:35:24 21 be? A skin rash type thing.

14:35:28 22 Q. And the next part says:

14:35:34 23 "Your RIA/MDS assignments from
14:35:37 24 December 25 to February 7 you
14:35:39 25 scored 0 out of 105. No bedside
14:35:43 26 assessments. Some PCC
14:35:44 27 assessments."

14:35:45 28 Is that Point Click Care?

14:35:49 29 A. Yes, they had different
14:35:50 30 assessments to do under Point Click Care.

14:35:54 31 Q. Is this the nursing staff?

14:35:56 32 A. Yes.

14:35:56 1 Q. And what type of assessments
14:35:59 2 would they be having to do?
14:36:00 3 A. Well, I can't, you know --
14:36:04 4 Q. That is okay. We are
14:36:05 5 having --
14:36:07 6 A. Ask the nurses, I think that
14:36:07 7 would be better.
14:36:08 8 Q. Okay. So in any event, she
14:36:11 9 hadn't done those assessments; is that correct?
14:36:13 10 A. That's correct. She hadn't
14:36:14 11 done any.
14:36:15 12 Q. And did she give any excuse
14:36:17 13 for not having done any?
14:36:19 14 A. No, not that is documented.
14:36:25 15 Q. And it says towards the
14:36:29 16 bottom:
14:36:30 17 "This will be a verbal. You are
14:36:31 18 front line staff and are
14:36:32 19 expected to be part of this for
14:36:34 20 our funding."
14:36:35 21 A. That's correct.
14:36:35 22 Q. And do you know, was that a
14:36:36 23 reference to the RAI/MDS system?
14:36:39 24 A. Yes, yes.
14:36:40 25 Q. Okay. And I won't take you
14:36:41 26 to them, but there's two Disciplinary Action
14:36:47 27 Forms at this point in time in February 2011.
14:36:52 28 They are both dated February 8th and they are
14:36:54 29 both, for the benefit of counsel, found at
14:37:00 30 document number 16875.
14:37:05 31 And on different forms you gave
14:37:07 32 Ms. Wettlaufer a verbal warning, so on one form

14:37:09 1 is a verbal warning for not doing the RAI/MDS,
14:37:13 2 and on another form no treatments done,
14:37:16 3 including a treatment for a stage 4 ulcer.

14:37:19 4 Now, why two verbal warnings on
14:37:23 5 the same day?

14:37:24 6 A. Well, it was my understanding
14:37:25 7 that we shouldn't talk about different issues
14:37:36 8 that occurred on different days, for instance,
14:37:41 9 at the same meeting. That would be, like,
14:37:44 10 compiling things. So I didn't want to put it
14:37:47 11 on one form, but in the interests of time for
14:37:52 12 the RNs and ourselves, I thought I would put it
14:37:56 13 on two forms because they were two different,
14:37:59 14 you know, types of things, and I wanted her
14:38:04 15 behaviour to change and I wanted it to be
14:38:08 16 documented.

14:38:09 17 Q. And so it identifies on your
14:38:13 18 sheets that you used progressive discipline.
14:38:16 19 What was your recollection of progressive
14:38:19 20 discipline and how it worked in the home?

14:38:21 21 A. My recollection is that it
14:38:25 22 started off with a counselling. We would
14:38:28 23 always bring the issue to the staff member
14:38:34 24 verbally and counselling wasn't considered
14:38:39 25 discipline.

14:38:41 26 And then it would progress to a
14:38:43 27 verbal warning, a written warning, a one-day
14:38:47 28 suspension, a three-day suspension, a five-day
14:38:50 29 suspension, and then termination.

14:38:53 30 Q. And where did you gain that
14:38:56 31 understanding from?

14:38:57 32 A. In my dealings with the

1 union.

2 Q. Okay. And so on this
3 particular occasion there's two things that she
4 has done; one is failure to do the RAI/MDS
5 audits, and the second one is failure to do
6 treatments for a stage 4 ulcer.

7 A. Uhm-hmm.

8 Q. Why wouldn't you progress and
9 give her on the same day a verbal and then a
10 written?

11 A. I am -- I thought I made a
12 good decision. I would have discussed it with
13 Marie and this is what we decided would be
14 fair.

15 Q. Okay, thank you.

16 Now, if we go to tab number Q,
17 which is document number 16873. Now, it is
18 dated March 8th, '08 but in the body it
19 identifies you were working March 3rd, 2011. I
20 think your affidavit indicates that you just
21 believe the date '08 is wrong; is that correct?

22 A. Yes, that's correct.

23 Q. All right. And this is a
24 meeting with Bethe Wettlaufer, Helen Crombez,
25 Karen Routledge as the ONA rep and Ms. Buckrell
26 again?

27 A. Yes.

28 Q. And it indicates in this
29 document:

30 "I started and finished the 24
31 hour assessment, I even stayed
32 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 1 is that just registered staff or just --

14:42:39 2 A. It was just the registered

14:42:41 3 staff, yes.

14:42:42 4 Q. So whoever was on shift would

14:42:44 5 assist one another with these assessments?

14:42:46 6 A. Yes.

14:42:47 7 Q. And Ms. Wettlaufer states --

14:42:54 8 or sorry, I shouldn't say states. Down the

14:42:56 9 side of the document where it says:

14:43:02 10 "Bethe, I stayed until the

14:43:06 11 2340-2345 and did not put in for

14:43:08 12 overtime. I did not

14:43:09 13 specifically tell May to start

14:43:11 14 the care plan."

14:43:15 15 Is that Ms. Wettlaufer speaking?

14:43:16 16 A. Yes, it is.

14:43:17 17 Q. And then is that you speaking

14:43:19 18 next?

14:43:20 19 A. Yes, I reminded her that, you

14:43:22 20 know, she should be reminding or telling her

14:43:26 21 co-worker that, you know, I got this and this

14:43:31 22 done but the care plan still needs work.

14:43:34 23 Q. Now, is it -- is the issue

14:43:42 24 that she didn't complete it or she didn't tell

14:43:44 25 the next shift?

14:43:45 26 A. I felt that she did make some

14:43:51 27 attempt to do the work. I noted here that

14:43:58 28 Agatha had started the 24-hour assessment, and,

14:44:00 29 you know, that needs to be done before the care

14:44:02 30 plan is really started.

14:44:06 31 So if Bethe finished that piece

14:44:11 32 of the work and stayed later to do it, I

14:44:17 1 thought that was appropriate.

14:44:20 2 Q. All right. And if I can turn
14:44:22 3 you to, in that same tab Q, document 16872, and
14:44:46 4 this is -- other than some handwriting on it,
14:44:48 5 it is not signed by anybody; do you see that?

14:44:50 6 A. That's right.

14:44:54 7 Q. Now, whose handwriting is on
14:44:58 8 the top?

14:45:00 9 A. That is my handwriting.

14:45:01 10 Q. And what does it state?

14:45:06 11 A. That we didn't give her
14:45:09 12 discipline because she did complete the 24-hour
14:45:11 13 trigger and the head-to-toe assessment, and
14:45:16 14 that I also noted that she did not give
14:45:18 15 specific instruction to May to complete the
14:45:22 16 24-hour care plan, or at least start it.

14:45:25 17 Q. So is it fair to say that on
14:45:27 18 this particular occasion there was -- other
14:45:30 19 than your meeting with her, there was no
14:45:31 20 discipline?

14:45:32 21 A. That's correct.

14:45:33 22 Q. And, sorry, that was wrongly
14:45:35 23 phrased. The meeting itself wasn't discipline;
14:45:38 24 it was investigation, is that correct?

14:45:39 25 A. That's correct.

14:45:40 26 Q. Thank you, Helen, for dealing
14:45:46 27 with those.

14:45:49 28 The next item that I am going to
14:45:50 29 deal with is an item with a resident that I
14:45:54 30 know that you know very well.

14:45:57 31 A. Uhm-hmm.

14:45:57 32 Q. And again, I just want to

1 remind both of us not to use the resident's
2 name. Okay?

3 A. Yes.

4 Q. All right. And so if I can
5 take you to tab number R, which is document
6 number 00522.

7 A. Yes.

8 Q. This is a Critical Incident
9 Report. We have gone over it yesterday with
10 Ms. Van Quaethem. It is dated January 30th,
11 2012 -- submitted January 30th, 2012, but dated
12 January 12th, 2012.

13 Now, before we get into the
14 incident, and without providing us with any
15 personal identifiers, did you know this
16 resident?

17 A. Yes.

18 Q. And what type of relationship
19 did you and she have?

20 A. We had a very good
21 relationship. I had gotten to know her in the
22 retirement home when she lived there. She
23 turned 62 this year in December, and I knew her
24 before, a couple of years at least before her
25 40th birthday because I remember Bonnie Hughes,
26 who was the retirement home manager at the
27 time, giving her a birthday party for her 40th
28 birthday in the retirement home because she
29 felt there was not a lot of family support.

30 And this resident would walk the
31 hallway until she found someone to complain to,
32 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.

1 Q. Now, what are your
2 obligations as a facility when a resident comes
3 and identifies to you that she has been slapped
4 by a Registered Nurse?

5 A. Well, we are to report it.
6 Our procedure was to investigate incidents
7 first and then report.

8 Q. That was your practice, was
9 it?

10 A. That was our practice, yes.

11 Q. And in this particular issue,
12 the evidence indicates that went through with
13 Ms. Van Quaethem that the resident came back
14 and apologized on January the 16th, I believe,
15 but then called the Ministry herself. Is that
16 your recollection?

17 A. Yes.

18 Q. Now, why in this particular
19 case, based upon -- and I guess, number one,
20 did you investigate?

21 A. Yes, we did. We asked the
22 resident to come to the Administrator's office
23 and we talked to her. And Brenda asked her to
24 demonstrate how she was hit and to try and use
25 the same amount of force as was used by Bethe
26 against her.

27 Q. And did the resident do that?

28 A. She had complained that she
29 had been slapped, and she said that several
30 times. And what she demonstrated to Brenda,
31 you know, was a punch and it wasn't -- you
32 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.

1 Q. And how often would you get
2 that training?

3 A. We had the initial training
4 and then we would review our abuse policy every
5 year.

6 Q. All right. And in any part
7 of that training, did they identify that you
8 can do your own investigation, and if you
9 conclude it didn't happen, then you shouldn't
10 report to the Ministry?

11 A. Well, that was -- that was my
12 belief at the time, yes.

13 Q. So if this resident had not
14 called the Ministry herself, the Ministry would
15 not have known that there was an allegation
16 that she had been slapped?

17 A. That's correct.

18 Q. Now, you said that was your
19 understanding at the time?

20 A. Yes.

21 Q. Did that understanding ever
22 change?

23 A. Yes. We had an annual
24 inspection in 2000 and -- I forget now, I have
25 it in my affidavit, I just forget the year.
26 And the inspector said to both Brenda and I
27 that it would be to our benefit to report
28 things immediately before investigating, and
29 that is not how we had looked at it before.

30 Q. All right. And are you aware
31 as to whether the Ministry actually came in and
32 investigated it once they got the Incident

1 Reports?

2 A. I don't believe they did.

3 There was a phone call, I think.

4 Q. All right. And before we
5 leave this subject, there is a Disciplinary
6 Action Form for Bethe Wettlaufer dated February
7 22nd, 2012, at Exhibit T, document number
8 16840.

9 A. Yes.

10 Q. And it identifies that she is
11 given a counselling with notice. Can you
12 identify for us what the incident was?

13 A. She had an:

14 "Inappropriate conversation with
15 a resident regarding telling her
16 [she] would not longer stand for
17 being bullied."

18 And I told her that this was
19 inappropriate, as you are the registered staff
20 and need to remain calm and professional at all
21 times.

22 Q. And you indicate in your
23 affidavit that this may have involved the same
24 resident that claimed that Elizabeth Wettlaufer
25 had slapped?

26 A. Yes, I believe that is true.

27 Q. And I didn't see that
28 particular allegation that Elizabeth Wettlaufer
29 had had an inappropriate conversation with a
30 resident; I didn't see it referenced in any of
31 the Critical Incident Reports that you filed.
32 Was there a reason that it wouldn't be included

1 in either the first report or an amendment
2 later?

3 A. I think I just didn't think
4 of it.

5 Q. All right. How did the
6 situation end up, without using any either
7 family names or identifiers or the resident's
8 name? How did it resolve itself between
9 Elizabeth and this particular resident, if at
10 all?

11 A. Well, this resident never
12 particularly liked Bethe, but I believe they
13 had a satisfactory relationship.

14 Q. Was there --

15 A. She wasn't -- I think we
16 moved her -- I believe we moved the resident to
17 East Wing, so then Bethe wouldn't be her
18 immediate nurse and she wouldn't have such
19 close interaction with her, unless it happened
20 on night shift.

21 Q. Your affidavit indicates that
22 there -- and this is at paragraph number 130:

23 "These issues were resolved at a
24 family meeting February 24,
25 2012. Elizabeth Wettlaufer was
26 there. They apologized to each
27 other and goals were set. After
28 the meeting the resident asked
29 the Ministry not to come in."

30 Is that your recollection?

31 A. Yes, from the documentation,
32 yes.

1 Q. Now, my understanding from
2 your affidavit is that the resident moved out
3 of the home shortly thereafter?

4 A. Yes.

5 Q. I know, it is very hard. The
6 resident.

7 A. She was not happy in the
8 home, and she had, you know, many complaints.
9 She didn't like the meals, we used too much
10 onion, she didn't enjoy the activities.

11 Q. All right, so she left --

12 A. There was quite a list.

13 Q. -- the facility?

14 A. Yes, she left the facility,
15 and, you know, that was a bit of a process. I
16 really wanted it to work for her, because I had
17 tried it once before and it didn't work because
18 she couldn't manage her own money.

19 So I talked to her older sister,
20 who lived quite a distance away --

21 Q. Okay, I am just going to --
22 I know you have a lot of information about this
23 particular resident, so I'm going to phrase it
24 this way.

25 Did you -- after she left and
26 you assisted her with those types of personal
27 things, did you and her remain in contact?

28 A. Yes.

29 Q. And would you see each other?

30 A. Yes.

31 Q. And what are the types of
32 things that you would see each other for?

1 A. We would go out for supper.
2 We would go shopping.

3 Q. All right.

4 A. She had tickets to a play and
5 she invited me to accompany her, like at the
6 Woodstock Theatre. And, yeah, we did lots of
7 things.

8 Q. All right. So that was in a
9 period between January 12th, 2012, and the
10 family meeting, as we understand it, is
11 February 24th, 2012. The documents indicate
12 that there were other issues being raised in
13 January 2012 about Bethe Wettlaufer. Do you
14 remember there being some issues?

15 A. I can't recall them without
16 looking at them.

17 Q. All right. Well, we'll go
18 through them.

19 First of all, there's some
20 documents that are dated, and I won't take you
21 to them for a minute, Amanda, but I'm going to
22 take you through some documents that were
23 received January 14th and January 15th, 2012,
24 but I noted in your affidavit and in the
25 documents there is a meeting on January 12th,
26 so before the notes came in, with Ms.
27 Wettlaufer about all these issues.

28 So do you know why you would
29 have a meeting about all these issues and then
30 receive written documentation?

31 A. Well, I think we heard about
32 it by word of mouth, or I did, and I asked the

1 staff if they knew of anything and I asked for
2 their comments.

3 Q. Okay. So if I can first turn
4 you to document number 16848, which is at your
5 Exhibit V.

6 A. B?

7 Q. "V" as in "victor."

8 Now, have you had an opportunity
9 before today to read this document?

10 A. Yes, this is not the document
11 that I was referring to when I said that we
12 heard things verbally.

13 Q. Yes, you are talking -- that
14 was the --

15 A. That was another incident
16 entirely, yeah.

17 Q. Well, this -- the document we
18 were talking about is your notes dated January
19 the 12th, but these are the documents that you
20 were receiving in January 2012?

21 A. That's correct.

22 Q. All right. So this first
23 one, you have had an opportunity to review it,
24 though, before today?

25 A. Yes, I have.

26 Q. And can you tell us from your
27 perspective -- and I read this into the record
28 yesterday. It is first about an individual
29 that was having difficulty breathing, according
30 to this person, and Bethe didn't respond to
31 assess the resident for a couple of days.

32 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

1 over?

2 A. It was totally inappropriate.
3 I would expect the Registered Nurse to get up
4 off her break and split her break and meet the
5 resident's needs.

6 Q. And sleeping in the chapel on
7 break, was that something that was allowed?

8 A. That was totally unacceptable
9 as well.

10 Q. But how would you classify
11 what she actually was doing in terms of those
12 residents that were looking for something for
13 their pain and had to wait?

14 A. Sorry, could you repeat that,
15 please?

16 Q. I guess my question is this.
17 Why wouldn't that be neglect? A resident wants
18 a pain medication and they are being told to
19 wait. In your experience, why wouldn't that be
20 classified as neglect?

21 A. It is very important when a
22 resident has pain to try and keep the pain at a
23 manageable level, and the longer you make them
24 wait, the harder it is to bring it back under
25 control. And we used to say if pain is 4, do
26 more.

27 Q. All right. And so why not
28 report this to the Ministry? Why wasn't it a
29 reportable situation?

30 A. Again, I probably didn't
31 think of it.

32 Q. Okay. Now, in around this

1 time as well you received a letter from
2 Jennifer Slyfield and this had to do as well
3 with a situation in which a resident was being
4 disimpacted. I am not going to bring it up,
5 Amanda. It is document, for the sake of
6 everyone else, document 16852.

7 A. Yes.

8 Q. And it has two things in
9 there. One about a resident being disimpacted
10 and in agony, and instead of the nurse stopping
11 and giving the resident a PRN for pain
12 medication, she just kept digging further. It
13 also involves a situation in which someone was
14 -- Bethe was paged and someone else had to
15 respond to a situation.

16 You became aware of this whole
17 issue of disimpacting the resident, correct, at
18 the time?

19 A. Sorry, say --

20 Q. You became aware that there
21 was an allegation?

22 A. Yes, yes, and I asked again
23 for documentation.

24 Q. All right. And you received
25 this documentation on January 14, 2016?

26 A. Yes.

27 Q. And you read it?

28 A. Yes.

29 Q. All right. Now, I am not a
30 Registered Nurse, far from it, so I'm not
31 exactly sure what is a disimpaction? If you
32 could just explain what the process is, what is

1 it and what is the process?

2 A. Well, normally, the PSW would
3 bring, you know, that to a Registered Nurse's
4 attention that the resident was having
5 difficulty moving their bowels and there would
6 be rectal bulging and cramping, and the
7 resident would be in distress.

8 So the nurse would respond by
9 getting her gloves and lubricant and go to the
10 room and try and assist the resident by either
11 removing some of the stool or pushing it back
12 up the bowel to reconfigure it so that it could
13 be passed.

14 Q. And what is the general
15 experience for residents when this is
16 happening?

17 A. It is quite painful.

18 Q. All right. And when you
19 viewed the document, did you come to any
20 conclusion as to -- the document and met with
21 Ms. Wettlaufer, did you come to any conclusion
22 as to the appropriate level of her care?

23 A. Well, I felt that Jennifer
24 Slyfield's comment about stopping to give a PRN
25 wasn't realistic. I would, you know, never
26 stop a bowel disimpaction to give a PRN. I
27 would try and, you know, talk to the resident
28 and try and finish what needed to be done.

29 And usually, you know, there is
30 relief with that, that the person is grateful
31 that, you know, it was done.

32 Q. And did you follow up with

15:13:48 1 this particular situation or make any changes?

15:13:53 2 A. Yes, I reviewed the bowel
15:14:03 3 protocol for the resident and spoke to the
15:14:10 4 Charge Nurse. I believe we looked at it
15:14:15 5 together and reviewed her bowel protocol, and
15:14:19 6 we had started using Lactulose for a number of
15:14:24 7 residents with good effect, and it was
15:14:29 8 something that could be adjusted as far as the
15:14:33 9 amount to be given and the frequency to be
15:14:37 10 given, you know, as the resident needed
15:14:42 11 adjustment, you know, with the doctor's order
15:14:47 12 to make it very successful for them.

15:14:55 13 Q. All right, thank you.

15:14:58 14 Commissioner, did you want to
15:15:00 15 take the afternoon break?

15:15:02 16 THE COMMISSIONER: Yes, if this
15:15:03 17 is a good time --

15:15:03 18 MS. HEWITT: Yes, thank you.

15:15:04 19 THE COMMISSIONER: -- for the
15:15:07 20 break.

15:15:07 21 -- RECESSED AT 3:15 P.M.

15:34:17 22 -- RESUMED AT 3:33 P.M.

15:34:17 23 THE COMMISSIONER: Go ahead, Ms.
15:34:18 24 Hewitt, when you are ready.

15:34:19 25 BY MS. HEWITT:

15:34:20 26 Q. Thank you, Commissioner.

15:34:21 27 Helen, before the break we were
15:34:24 28 talking about some incidents that had occurred
15:34:28 29 or some reports that you had received in
15:34:30 30 January of 2012, and I just want to take you to
15:34:34 31 a couple more documents on this particular
15:34:36 32 area.

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

7 A. Yes.

8 Q. Do you recall Wendy?

9 A. Yes, I do.

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

12 A. Yes.

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

17 A. Yes.

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

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

27 A. Yes, I have.

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

32 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

1 know, I could think of, you know, myself in
2 situations where I had experienced a serious
3 fall, I remember one in particular in the
4 dining room, and, you know, there was a lot of
5 blood and maybe there wasn't a head injury
6 because the pressure, you know, was relieved, I
7 don't know. But sometimes it looks worse than
8 what it is.

9 Q. Well, let's talk about the
10 hematoma situation.

11 A. Uhm-hmm.

12 Q. You said that Bethe
13 Wettlaufer said that she has been trained and
14 she knew what to do, she knew what she was
15 doing?

16 A. Uhm-hmm.

17 Q. You are a nurse as well;
18 correct?

19 A. Uhm-hmm.

20 Q. And so what was your view of
21 what the normal practice would be if there was
22 a hematoma that was developing on someone's
23 leg?

24 A. The normal practice would be
25 to, you know, apply a cold cloth or ice, if you
26 could get it, to try and stop the bleeding, and
27 then to cover, you know, the area with an ABD
28 pad, which was, you know, like a one-inch pad.
29 It was on a roll and you could cut it off to
30 the size that you wanted. And then wrap that
31 around the leg with a cling bandage to protect
32 it, so that if the resident bumped it again, it

1 wouldn't break the skin.

2 Q. Now, she says that she has
3 been trained and knows what she had been doing,
4 but is it normal to puncture something without
5 sterilizing the equipment first?

6 A. No, it certainly is not.

7 Q. All right. And in that same
8 letter Ms. MacKnott talks about the fact that
9 she had brought to Ms. Wettlaufer's attention
10 that another resident had -- appeared to have
11 some sort of a wound on her fingers and that it
12 was bleeding?

13 A. Yes.

14 Q. And had asked Ms. Wettlaufer
15 to assess that particular resident?

16 A. Uhm-hmm, that's correct.

17 Q. Did she assess that resident?

18 A. No, she didn't.

19 Q. All right. And in those two
20 instances, there wasn't a report -- there was a
21 report to the Ministry in respect of the
22 resident's fall and transfer to hospital;
23 correct?

24 A. That's correct.

25 Q. But there was no reports to
26 the Ministry in respect of the treatment that
27 they received?

28 A. That's correct. And, you
29 know, after reviewing the documentation, I
30 assumed, I think, that the puncture wound or
31 the popping wound was the smaller of the two
32 wounds, and, you know, that healed very well.

1 Q. And the wound that had led,
2 I'm assuming, to the blood on the floor, did
3 that heal well or did it not heal well?

4 A. No, it did not heal well, and
5 you know, there was a lot of blood on the
6 floor, so I think I assumed it was the larger
7 of the two. I can't explain -- you know, I was
8 watching this resident closely. She had gone
9 to hospital and came back saying that there was
10 no fracture.

11 And then she spent most of the
12 day in bed, which was very unusual for her.
13 And she did have dementia, and usually with
14 dementia -- you know, and we did give her pain
15 medication, I'm quite sure of that.

16 Usually with dementia, they
17 forget that they have an injury and just resume
18 their normal practice. And she wasn't moving.
19 And, you know, she was eating, you know, fairly
20 well and drinking fairly well, and I would go
21 and see her at different times of the day just
22 to check on her.

23 And I was beginning to think
24 that maybe the x-ray missed something, because
25 she wasn't moving. And I had had the
26 experience in the past with a cognitive
27 resident who had had a fall and who we sent
28 back to hospital three or four times, you know,
29 over several months because she would cry to me
30 and say, Helen, there is something wrong. I
31 have never had pain like this before.

32 And we finally, you know, with

15:43:09 1 repeated x-ray found that she had a pelvic
15:43:12 2 fracture. And I was starting to think that
15:43:13 3 perhaps the same thing had happened to this
15:43:16 4 resident, that, you know, the x-ray missed
15:43:17 5 something.

15:43:18 6 And I was talking to one of the
15:43:21 7 other -- or one of the RPNs who was our skin
15:43:26 8 care person, and I asked her, you know, how
15:43:29 9 that wound was healing, and, you know, I asked
15:43:36 10 her about the right one because I thought that
15:43:39 11 was the puncture one, and she said, oh, she
15:43:42 12 said, that looked, you know, good on the first
15:43:45 13 day, she said, the day after, she said. And
15:43:49 14 then she kind of thought, she said it was
15:43:51 15 completely healed in three days, and I think
15:43:53 16 this must have been about day four.

15:43:55 17 And she asked me, do you want
15:43:56 18 her to go back to hospital? Because I
15:44:00 19 explained what I was thinking. And I said,
15:44:02 20 well, let's give it another day or two. And
15:44:05 21 then by the fifth day she started, you know,
15:44:08 22 being more herself, getting up, you know, and
15:44:14 23 more mobile.

15:44:15 24 Q. All right. Now, with the
15:44:18 25 failure of Ms. Wettlaufer to go and examine the
15:44:21 26 other resident's finger, maybe you can just
15:44:26 27 educate the Commissioner and I as to your
15:44:29 28 mandatory obligations to report neglect or
15:44:33 29 incompetent treatment. What is the definition
15:44:36 30 of "neglect"? What did you see would rise to
15:44:40 31 the level that would need to have mandatory
15:44:43 32 reporting?

1 A. Well, neglect is, you know,
2 not doing something that you should do for a
3 resident. And I don't know. You know, I don't
4 know if I had a mental block about neglect, but
5 I really didn't think of it, as far as I can,
6 you know, recall.

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

10 A. Yes.

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

17 A. Well, sometime I think in,
18 you know, about the middle of 2012, we were
19 given some education on this, and they were
20 decision trees.

21 Q. And is that what you went by,
22 these decision trees?

23 A. I can't recall if I -- we
24 looked at them often, Brenda and I, but I can't
25 recall whether I looked at it for this
26 incident.

27 Q. Okay, I think -- if I can
28 just have one moment, Commissioner.

29 THE COMMISSIONER: Yes.

30 MS. HEWITT: If I could ask that
31 document 16542 be put on the
32 screen. That is in the Overview

15:46:31 1 Report, Commissioner. It is not
15:46:32 2 in your exhibit book.

15:46:36 3 THE COMMISSIONER: All right,
15:46:37 4 thank you.

15:46:38 5 BY MS. HEWITT:

15:46:38 6 Q. It may be a little bit
15:46:39 7 difficult to read. We may have to zoom in.

15:46:51 8 Now, this document at the bottom
15:47:01 9 is dated May 2012. Oh, thank you very much. I
15:47:08 10 can actually read this version. Do you see
15:47:10 11 that document?

15:47:11 12 A. Yes, I do.

15:47:12 13 Q. And is this the decision tree
15:47:14 14 that you are referring to?

15:47:15 15 A. Yes, it is.

15:47:16 16 Q. All right. And so maybe you
15:47:21 17 can simply help take us through it, because you
15:47:23 18 would be more familiar with this document than
15:47:25 19 we would.

15:47:26 20 A. So starting at the top, it is
15:47:33 21 "Alleged, suspected or witnessed neglect of a
15:47:36 22 resident by licensee or staff," and to the
15:47:44 23 right it says:

15:47:46 24 "Licensee to immediately
15:47:47 25 investigate and take action in
15:47:48 26 response to the incident."

15:47:51 27 And if you go towards the
15:47:56 28 bottom:

15:47:57 29 "Are there reasonable grounds to
15:47:58 30 suspect that neglect has
15:48:00 31 occurred or may occur?"

15:48:04 32 And if you read to the right, it

15:48:06 1 says:
15:48:07 2 "To determine [...]"
15:48:10 3 I am not sure what is in that
15:48:14 4 dark box.
15:48:15 5 Q. It says:
15:48:16 6 "Immediately answer the
15:48:16 7 following question."
15:48:18 8 And then if you go further to
15:48:19 9 the right?
15:48:21 10 "Did licensee or staff fail
15:48:23 11 to provide a resident with
15:48:24 12 treatment, care, services or
15:48:25 13 assistance required for health,
15:48:27 14 safety or well-being?
15:48:28 15 Note: Can include inaction or a
15:48:30 16 pattern of inaction that
15:48:32 17 jeopardizes the health, safety
15:48:33 18 or well-being of one or more
15:48:35 19 residents."
15:48:38 20 And then if the answer is yes,
15:48:41 21 then we are to:
15:48:44 22 "Immediately report suspicion
15:48:48 23 and inform the director (via
15:48:53 24 Critical Incident Report as per
15:48:54 25 memo)."
15:48:57 26 And if it is after hours, we can
15:48:59 27 use the pager number.
15:49:01 28 Q. Okay. Now, this came out in
15:49:03 29 2012. Had you had training on abuse and
15:49:07 30 neglect prior to 2012?
15:49:09 31 A. Oh, yes.
15:49:11 32 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

1 nurse's, you know, situation, I kept that in
2 mind. And she did give Wendy instruction to
3 take some gauze and wrap her finger. And, you
4 know, I don't know, a fall is a lot of work.
5 You have to get a copy of the MAR. You have to
6 fill out the transfer form. You have to, you
7 know, call the family, call the doctor for a
8 transfer order. So there is a lot of work
9 involved. Plus she had her morning medications
10 to give.

11 Q. Now, if I'm reading Ms.
12 MacKnott's notes correctly, the fall was after
13 2 o'clock in the morning. Is that your
14 recollection?

15 A. Yes.

16 Q. So this would be the night
17 shift?

18 A. That's correct.

19 Q. And so the only individuals
20 on the night shift, I think since we looked at
21 that chart, would be Ms. Wettlaufer and an RPN
22 in terms of staffing?

23 A. That's correct.

24 Q. And Ms. Wettlaufer, from your
25 evidence, would be involved -- would have to be
26 involved with this fall; is that correct?

27 A. That's correct.

28 Q. And in retrospect, do you
29 have any other opinion now as to whether in
30 those instances, those things should be
31 reported or --

32 A. Yes, I do. I should have

1 reported it right away and investigated after.

2 Q. I do want to take you to your
3 notes with Bethe Wettlaufer on January 12th,
4 which is found, Commissioner, at tab number U,
5 document number 16853.

6 All right. And I won't go over
7 all of these because we have already referred
8 to some of it. But if I can take you to --
9 first of all, could I ask you, the only person
10 that is identified as attending on these notes
11 is Karen Routledge; is that correct?

12 A. Yes, but I was there. I was
13 the one talking. My initials are in the
14 margin, and this is Brenda's writing, and we
15 were speaking to Bethe.

16 Q. All right. So if I can take
17 you then to the second page and the question is
18 there:

19 "What did you do with left
20 hematoma. You took what and
21 punctured the skin.
22 I took scissors and poked at it.
23 Were the scissors sterile?
24 No, they were not.
25 It would have been appropriate
26 to wash the skin and apply
27 pressure."

28 Who is speaking there and
29 talking about washing the skin and applying
30 pressure?

31 A. That is myself.

32 Q. And then on the next page,

15:54:05 1 there is the items that I already talked you to
15:54:09 2 about the person's finger bleeding. And then
15:54:18 3 if I can take you down to the bottom of that
15:54:21 4 third page, starting at "Break should be [...]"

15:54:31 5 A. Yes.

15:54:32 6 Q. "Breaks should be 1/2 or 15
15:54:38 7 minute - 2 times"

15:54:43 8 What were you referring to in
15:54:44 9 that particular situation about her breaks?

15:54:45 10 A. I was just reminding her that
15:54:47 11 her breaks should be either a half hour in
15:54:51 12 length or, if she was interrupted, to take two
15:54:58 13 15-minute breaks or a 10-minute break and a
15:55:01 14 20-minute break, it doesn't really matter.

15:55:04 15 Q. And why did that discussion
15:55:05 16 come up?

15:55:06 17 A. I can't recall off the top of
15:55:07 18 my head.

15:55:07 19 Q. All right. And then it goes
15:55:08 20 on to say:

15:55:09 21 "Not acceptable for residents to
15:55:12 22 wait."

15:55:14 23 Who would have said that?

15:55:15 24 A. I would have said that.

15:55:17 25 Q. And the top of the next page:

15:55:21 26 "I will take break separated."

15:55:24 27 Is that Ms. Wettlaufer?

15:55:26 28 A. Yes.

15:55:27 29 Q. And then if we go to the
15:55:32 30 bottom of the page, it has the title "Wounds -
15:55:37 31 apply pressure and cover," and then it has a
15:55:40 32 night shift routine?

1 A. Yes, I reviewed the night
2 shift routine with her as an education.

3 Q. All right. And how was she
4 in this particular meeting?

5 A. I thought she was receptive.
6 You know, she talked politely.

7 Q. All right. Now, we do know,
8 and I won't take you to it, but it is document
9 number Y at 16842, that Bethe Wettlaufer then
10 -- so this meeting is January 12th. On January
11 16th, 2012, you gave her discipline, a written
12 warning, and it was for not meeting the
13 required needs of residents in a timely manner,
14 not following policy and procedure after a
15 fall.

16 So was that the result of your
17 investigation into these issues?

18 A. Yes.

19 Q. All right. So why only a
20 written warning? Why was this not serious
21 enough to do something more serious, from your
22 perspective?

23 A. Well, I'm not, you know, sure
24 without looking at a chart where we were at
25 with discipline, if it had been some time since
26 we had talked to her.

27 Q. I can help you with that,
28 because it is in the meeting or in your notes,
29 and in respect of this, this is January 16th,
30 2012?

31 A. Actually, it is right on the
32 form. She had a counselling on March the 3rd,

15:57:36 1 2011, and a verbal warning February 2nd, 2011.

15:57:41 2 So we gave the next step which was a written.

15:57:43 3 Q. All right. Were you allowed
15:57:46 4 to skip it if you thought it was serious
15:57:48 5 enough?

15:57:49 6 A. Pardon me?

15:57:51 7 Q. Were you allowed to go to a
15:57:53 8 next step, skip a step?

15:57:55 9 A. Well, after a written is a
15:57:57 10 suspension, so we would need to talk to head
15:58:02 11 office about that.

15:58:02 12 Q. All right. Did you think
15:58:04 13 that these things were serious enough to talk
15:58:07 14 to head office about a suspension at the time?

15:58:09 15 A. I don't believe so. I
15:58:16 16 believe we would have if we thought it was
15:58:17 17 necessary.

15:58:18 18 Q. All right. Now, we have
15:58:21 19 spent quite a time going through your affidavit
15:58:25 20 and you do have a lengthy affidavit with a lot
15:58:27 21 of the information in it.

15:58:29 22 So I'm going to next go to a
15:58:34 23 meeting that you had with Bethe Wettlaufer on
15:58:37 24 September the 4th, 2012, and that is found at
15:58:44 25 Exhibit BB, and, Commissioner, that is document
15:58:51 26 number 16822. You see that document?

15:59:17 27 A. Yes, I do.

15:59:18 28 Q. And what was happening on
15:59:21 29 this particular occasion, September 4th, 2012?

15:59:23 30 A. The refrigerator temperatures
15:59:30 31 in Section B medication fridge were taken on
15:59:35 32 August 27th, 29th and 31st.

1 Q. And is that one of the duties
2 of a Registered Nurse is to take the
3 refrigerator temperatures?

4 A. Yes, because it is in the
5 locked room where the, you know, medications
6 are kept in the fridge, so it was a requirement
7 by the -- for the registered staff.

8 Q. And it goes on to say:
9 "Initials on the count but not
10 with on-coming shift."

11 Do you know what you are
12 referring to there?

13 A. Well, it looks like, you
14 know, she was counting incorrectly.

15 Q. And is this a narcotic count?

16 A. It would be the shift count,
17 I think. It is "initials on the count but not
18 with on-coming shift."

19 Q. Well, if we go two-thirds of
20 the way down, it says:

21 "What is the proper procedure on
22 coming count", something, "in
23 counted, both watching - pills
24 and what is written, watch what
25 is put back in the box.

26 Expected all proper process
27 followed by Reg. Staff. Helen
28 gave Bethe written warning."
29 That is not the narcotic count?

30 A. I think it is --

31 Q. I am going to --

32 A. I think this is shift count,

16:01:14 1 because "both watching," you know, she says --

16:01:19 2 Q. I'm going to stop you there,
16:01:20 3 Helen, and only because let's go to the
16:01:23 4 discipline, 16821. That might assist you.

16:01:27 5 Do you see that?

16:01:39 6 A. "Not counting narcotics as
16:01:48 7 per protocol on Monday [...] and
16:01:52 8 not taking med refrigerator
16:01:54 9 temperature on Friday [...] and
16:01:58 10 vaccine frig" on those three
16:02:02 11 other dates.

16:02:03 12 Q. Does that help in determining
16:02:04 13 what those notes were referring to? So these
16:02:16 14 notes that we were just referring to are dated
16:02:19 15 September 4th, 2012?

16:02:22 16 A. Uhm-hmm.

16:02:23 17 Q. And the discipline is
16:02:25 18 September 4, 2012?

16:02:30 19 A. Yeah, this is the narcotic
16:02:32 20 count at change of shift.

16:02:34 21 Q. Yes, okay, all right. I'll
16:02:37 22 move on then.

16:02:38 23 And she was given on this
16:02:43 24 particular day a written warning?

16:02:44 25 A. That's correct.

16:02:44 26 Q. All right. And in or around
16:02:47 27 that same time, there is another discipline,
16:02:51 28 this time it is August 31st, for not assessing
16:02:57 29 a resident as required, and this is at this
16:03:00 30 same tab. I'm not going to take you to it.

16:03:02 31 But I am going to take you to
16:03:04 32 the minute, or the meeting, which is at

16:03:07 1 document 16826. Do you see those notes?
16:03:23 2 A. Yes.
16:03:26 3 Q. All right, and it says:
16:03:28 4 "Why did you not respond to
16:03:31 5 Trish Brown's concern regarding
16:03:34 6 [Resident].
16:03:35 7 Told in report regarding swollen
16:03:36 8 left cheek.
16:03:39 9 Had seen her [...]"
16:03:41 10 What is that word?
16:03:42 11 A. Twitching, I think.
16:03:44 12 Q. "We had concerns with your
16:03:45 13 charting previously on August
16:03:48 14 8/12 and how you handled."
16:03:51 15 And it goes down to two-thirds
16:03:53 16 of the way down the page:
16:03:54 17 "Took keys home.
16:03:57 18 OCD and bipolar - changing
16:04:02 19 meds."
16:04:03 20 Then it says:
16:04:05 21 "Your assessment skills are not
16:04:06 22 up to par.
16:04:07 23 Documentation."
16:04:10 24 Is that Ms. Wettlaufer
16:04:10 25 identifying any issues to you?
16:04:12 26 A. Yes, she took the keys home
16:04:24 27 and she was telling us that she had OCD and
16:04:24 28 bipolar and that her doctor was changing her
16:04:27 29 medication.
16:04:28 30 Q. And when you say she took the
16:04:32 31 keys home, what keys would those be?
16:04:35 32 A. Those would be the keys to

16:04:37 1 the med room.

16:04:38 2 Q. The keys that she is supposed

16:04:43 3 to provide to the on-coming nurse?

16:04:44 4 A. Yes.

16:04:45 5 Q. All right, and at this time,

16:04:47 6 did she ask for any accommodation?

16:04:49 7 A. No, she did not.

16:04:51 8 Q. And did you discuss putting

16:04:56 9 her on a leave of absence or asking for any

16:04:58 10 documentation from her doctor yourself?

16:05:00 11 A. Well, we did talk to her. If

16:05:10 12 you could scroll down, I think we talked to her

16:05:11 13 about:

16:05:20 14 "Reg staff have a standard and

16:05:22 15 these are services [...],"

16:05:30 16 "these [serve as] [sic]

16:05:32 17 deficiencies."

16:05:33 18 Q. Or is that "these are serious

16:05:36 19 deficiencies"?

16:05:37 20 A. And "these are serious

16:05:39 21 deficiencies," yes.

16:05:40 22 Q. If I could take you to

16:05:42 23 document 16823. So this is the discipline.

16:05:59 24 And within this notice, it states:

16:06:02 25 "Written warning with notice

16:06:03 26 that continued poor performance

16:06:05 27 will result in disciplinary

16:06:06 28 action up to and including

16:06:08 29 termination. If continued poor

16:06:09 30 work performance related to

16:06:10 31 health issues continue,

16:06:12 32 consideration may be given to

16:06:13 1 report to the College of Nurses
16:06:14 2 for 'fitness to practice for
16:06:17 3 review' your health and
16:06:20 4 well-being is at our [ut]most
16:06:25 5 concern. Please follow-up with
16:06:27 6 the medical issues you discussed
16:06:29 7 with us."

16:06:31 8 So educate us as to what is a
16:06:34 9 fitness to practice review?

16:06:36 10 A. It is a review by the College
16:06:42 11 of Nurses to see if a registered member is in
16:06:45 12 fact fit to practice.

16:06:46 13 Q. And is that available to you
16:06:56 14 at any time?

16:06:57 15 A. I believe so.

16:06:58 16 Q. And is that the same thing as
16:07:02 17 reporting someone to the College of Nurses,
16:07:07 18 such as on a termination?

16:07:08 19 A. I don't think it is the same
16:07:12 20 as reporting. I think it is, you know, asking
16:07:15 21 for help.

16:07:16 22 Q. All right. And so by this
16:07:19 23 point in time why wouldn't you simply refer Ms.
16:07:25 24 Wettlaufer to the College of Nurses for this
16:07:29 25 fitness to practice review?

16:07:30 26 A. I think we were hoping to
16:07:36 27 make an impression that she would, you know,
16:07:41 28 change her behaviour.

16:07:43 29 Q. And on the bottom left-hand
16:07:45 30 side it says:

16:07:46 31 "Explained to Bethe that she
16:07:49 32 brought her health issues to us

16:07:51 1 and we are obligated to ensure
16:07:53 2 the safety of the Residents."
16:07:57 3 A. Yes.
16:07:57 4 Q. What did you mean by that?
16:07:59 5 A. Well, she told us that she
16:08:07 6 had issues with her medication change. I think
16:08:14 7 she used that as a reason for her performance.
16:08:22 8 And we wanted her to self-reflect, and if she
16:08:28 9 thought that she wasn't up to par, then, you
16:08:32 10 know, she should ask for a leave of absence.
16:08:35 11 Q. Why leave it in her hands to
16:08:38 12 self-reflect as to whether she wasn't up to par
16:08:41 13 versus your putting her off on a leave of
16:08:44 14 absence?
16:08:44 15 A. I don't know. I can't
16:08:52 16 recall.
16:08:52 17 Q. Did you ever refer her for a
16:08:56 18 fitness to practice review?
16:08:58 19 A. No, we did not.
16:08:59 20 Q. Okay. So I want to then go
16:09:05 21 to some issues that you had in terms of her
16:09:10 22 medications -- sorry, medication incidents, not
16:09:15 23 her medications.
16:09:16 24 And we have already dealt with
16:09:19 25 quite a few today, and if we go to -- I'll just
16:09:28 26 orient you, Helen, in your document as to the
16:09:38 27 paragraph that we are at.
16:09:40 28 So if we turn to paragraph 185
16:09:51 29 of your affidavit, it lists out how you
16:09:57 30 counselled or disciplined Elizabeth Wettlaufer
16:10:00 31 for her medication errors, and we have been
16:10:02 32 through quite a few and I know your affidavit

1 does refer to others.

2 A. Yes.

3 Q. And I am just waiting for it
4 to come up. So paragraph 185, approximately
5 page 38. You have got 138 as the page number.

6 MS. STRATTON: Sorry, I'm just
7 going to refresh.

8 BY MS. HEWITT:

9 Q. We seem to be having
10 technical difficulties. You are at paragraph
11 185 in your document?

12 A. Yes, I am.

13 Q. So we see, and we saw this
14 yesterday through Brenda, that by 2013 the
15 incidents are being met with a written notice
16 in February 2013, a one-day suspension in March
17 2013, a five-day suspension in April 2013, and
18 we heard evidence yesterday that that was
19 grieved and then withdrawn.

20 So I want to start with you at
21 the letter of counselling that is found at --
22 that is December the 19th, 2013. And that is
23 found at tab number 00, document number 16775.

24 A. Sorry, it is 00.

25 Q. It is 00, and it is the last
26 page in that particular tab.

27 A. Sorry.

28 Q. And this document indicates:

29 "This letter is to inform you
30 that you are not working to the
31 best of your ability. A
32 resident's family complained

16:13:13 1 that you administered two types
16:13:14 2 of eye drops at the same time.
16:13:16 3 At the investigation meeting
16:13:18 4 held today you admitted to doing
16:13:20 5 this stating you knew it was
16:13:22 6 wrong. The one eye drop was
16:13:24 7 scheduled for 16:30 and the
16:13:27 8 other at 20:00 p.m. You
16:13:30 9 confirmed you administered both
16:13:31 10 at approximately 18:30 p.m. The
16:13:34 11 family member has concerns for
16:13:36 12 her husband's eye condition and
16:13:38 13 knew the drops were administered
16:13:40 14 wrong."

16:13:43 15 And then at the bottom it

16:13:45 16 states:

16:13:45 17 "Bethe, we want you to take the
16:13:47 18 above seriously. We cannot
16:13:49 19 continue to have a good working
16:13:51 20 relationship [...] "

16:13:53 21 Now, do you remember this
16:13:55 22 particular incident?

16:13:55 23 A. After reviewing the
16:13:58 24 documentation, yes.

16:13:59 25 Q. And this document indicates
16:14:02 26 that Ms. Wettlaufer actually knew that she was
16:14:06 27 administering it wrong, not that she made a
16:14:09 28 mistake and later found it, but she knew at the
16:14:12 29 time that she was doing it that it was wrong?

16:14:15 30 A. Yes, she did admit that.

16:14:16 31 Q. And we just saw that you were
16:14:18 32 up to a five-day suspension in April of 2013,

1 and so can you explain why now in December of
2 2013 the next step which would be termination
3 was not followed?

4 A. I think Brenda and Wanda
5 discussed it, and it being the Christmas
6 season, because it sounds like we, you know,
7 investigated first and then called her back in,
8 because it says "at the investigation meeting
9 held today, you admitted," and then we gave her
10 this letter as a counselling with a strong
11 statement saying that, you know, she needed to
12 improve and that we couldn't continue to have a
13 good working relationship if these issues
14 continued.

15 Q. Okay. And in respect of that
16 particular situation, and I will take you to
17 the document if you wish, Helen, but there was
18 notes taken at a meeting with Bethe Wettlaufer,
19 Jennifer Hague, Helen and Brenda, so yourself
20 and Brenda, and those notes say the following:

21 "We are going to put this on
22 your file, very serious issues,
23 with the Christmas season, if we
24 sent this to HO the outcome
25 wouldn't be good."

26 Do you see that document?

27 A. Yes.

28 Q. Now, can you talk to us or
29 shed any light on by what is meant by those
30 particular comments?

31 A. Well, I think we did, you
32 know, say that to her, but then after the

1 meeting we reconsidered and sent it to -- or
2 Brenda talked to Wanda, because we didn't do
3 letters. We used our forms.

4 Q. So that letter, your
5 recollection of who drafted that letter is what
6 then?

7 A. That it came from Wanda at
8 head office, or that she had -- you know, she
9 sent it over to us and that is what we used.

10 Q. All right. Now, the next
11 incident with Ms. Wettlaufer that I want to
12 take you to is in January of 2014, so in this
13 particular time she is given a five-day
14 suspension. Do you remember that?

15 A. Yes.

16 Q. And part of why she is
17 suspended at that point in time, as I
18 understood it, involved Maureen Pickering; do
19 you remember that? That is one of our --

20 A. I would like to see the
21 documentation again.

22 Q. Yes, absolutely. So first
23 I'll take you to the termination letter, so you
24 can -- or the discipline letter so you can just
25 refresh your memory as to the discipline. That
26 is in tab number PP, document 16739.

27 And it says:

28 "This letter is to inform you
29 that you are not working to the
30 standards required for Caressant
31 Care. A resident was given
32 medication outside of the

16:18:26 1 allowable time frame, this same
16:18:28 2 resident was spoken to in an
16:18:30 3 inappropriate manner that
16:18:31 4 resulted in upsetting the
16:18:33 5 resident and you failed to
16:18:34 6 document the interventions that
16:18:36 7 you said you tried for this
16:18:38 8 resident. All of these issues
16:18:40 9 are being brought to your
16:18:41 10 attention. Please reflect on
16:18:42 11 your actions."

16:18:46 12 And then she is given a five-day
16:18:48 13 suspension. And in your affidavit at paragraph
16:18:51 14 214, page 43, you state:

16:18:55 15 "One of these incidents involved
16:18:57 16 one of Elizabeth Wettlaufer's
16:18:59 17 victims, Mrs. Pickering. The
16:19:02 18 Respirodone was supposed to be
16:19:04 19 given in the morning and instead
16:19:05 20 she gave it on evening shift."

16:19:07 21 Does that help at all?

16:19:09 22 A. Yes.

16:19:10 23 Q. All right. And do you
16:19:12 24 remember what incident or what Ms. Wettlaufer
16:19:19 25 said when it identifies "the resident was
16:19:25 26 spoken to in an inappropriate manner"?

16:19:27 27 A. She told the resident that
16:19:30 28 she had Alzheimer's and that she couldn't
16:19:35 29 remember things and, you know, she had to trust
16:19:40 30 the staff, or something to that effect.

16:19:41 31 Q. All right. If I can take you
16:19:43 32 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

1 particular discipline?

2 A. I am not aware of that or I
3 don't recall.

4 Q. Would you be involved in the
5 grievances?

6 A. No.

7 Q. Who would that be -- who
8 would be involved in the grievances?

9 A. That would be Brenda and head
10 office.

11 Q. So the last thing I want to
12 -- two more things, Helen.

13 Number one is we know that in
14 March of 2014 Elizabeth Wettlaufer was
15 terminated.

16 A. Uhm-hmm.

17 Q. And briefly can you describe
18 the circumstances surrounding why she was
19 terminated on that occasion?

20 And that is -- if you want help,
21 you do touch on it at paragraph 216 of your
22 affidavit.

23 A. The resident had run out of
24 insulin after the day shift administered it,
25 and that was Agatha, and she had left the
26 resident's insulin pen open on the medication
27 cart as a reminder to herself to explain to
28 Bethe that there was no insulin for this
29 resident and, you know, that the insulin would
30 be coming and could she put it in the pen.

31 And Bethe, for whatever reason,
32 didn't follow that instruction and she borrowed

1 insulin from another resident, either believing
2 that it was the same insulin or who knows.

3 Q. She put the wrong cartridge
4 in the pen?

5 A. She put the wrong cartridge
6 in the pen and gave her the wrong insulin. And
7 that continued over the weekend until Agatha
8 came back to work I believe on Monday, and then
9 Agatha, realizing that the resident wasn't
10 feeling well and thinking back to leaving the
11 pen, you know, for Bethe to refill, checked the
12 insulin, the type of insulin in the cartridge
13 and realized it was the wrong one.

14 Q. Now, over the course of that
15 weekend, it would have been more than Elizabeth
16 Wettlaufer that administered that insulin; is
17 that correct?

18 A. Yes, that's correct.

19 Q. And did you discipline any of
20 the other nurses that were involved?

21 A. No, I did not.

22 Q. So why discipline Elizabeth
23 Wettlaufer at this time then?

24 A. Because I felt or we felt
25 that it was on Bethe's mistake. She had been
26 directed, you know, how to put -- what to do
27 with the insulin, and she didn't follow
28 direction and the insulin got -- wasn't correct
29 and the resident had side effects, if you will,
30 from getting the wrong medication.

31 Q. Now, after the termination of
32 Ms. Wettlaufer, she was reported to the College

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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

16:26:34 1 there anything within those notes that you
16:26:37 2 disagreed with?

16:26:38 3 A. Yes, I --

16:26:42 4 Q. Would you like us to put them
16:26:44 5 up on the screen for you?

16:26:46 6 A. Yes.

16:26:47 7 Q. So it is document number
16:26:50 8 36847. And we'll scroll down a bit. Now, we
16:27:24 9 already know, just to help you, Helen, that the
16:27:27 10 date of 2005 on the first line is wrong. That
16:27:31 11 is actually the date, however, that is on the
16:27:33 12 report to the College, it is the wrong date of
16:27:40 13 hire for Ms. Wettlaufer. It should have been
16:27:42 14 2007.

16:27:42 15 But beyond that, this is Ms.
16:27:45 16 Yee's notes of what she purports to have been
16:27:48 17 your telephone conversation, and can you tell
16:27:53 18 us from -- do you have an independent
16:27:55 19 recollection now of the conversation?

16:27:56 20 A. No, I do not.

16:27:57 21 Q. So when you say there are
16:27:59 22 some things you disagree with, it is not
16:28:02 23 because of your independent recollection of the
16:28:04 24 actual conversation?

16:28:05 25 A. I believe, you know, that
16:28:09 26 there are some words missing.

16:28:12 27 Q. All right. So take us
16:28:15 28 through and let us know what you believe is
16:28:22 29 missing or inaccurate?

16:28:24 30 MR. SANDLER: Excuse me for a
16:28:26 31 moment. I'm not quite sure what
16:28:27 32 evidence is being elicited now,

16:28:29 1 because the witness says she has
16:28:30 2 no independent recollection
16:28:31 3 whatsoever of the conversation.
16:28:33 4 I don't know how she purports to
16:28:35 5 say what words are or are not
16:28:37 6 missing, and I have to say, and
16:28:38 7 I don't have any of this in an
16:28:39 8 affidavit or a summary or
16:28:40 9 anything, so I am not really in
16:28:42 10 a position to respond or make
16:28:44 11 fuller submissions on it. So if
16:28:47 12 my friend wants to elicit this,
16:28:49 13 I think it might be helpful if I
16:28:52 14 could have some sense before it
16:28:54 15 is elicited or what it is that
16:28:56 16 the witness is going to say to
16:28:57 17 see whether I would continue on
16:28:58 18 with that objection. As I say,
16:29:00 19 I don't have anything in a
16:29:02 20 summary in relation to this
16:29:03 21 whatsoever.

16:29:05 22 BY MS. HEWITT:

16:29:05 23 Q. All right. You have no
16:29:06 24 independent recollection of this conversation;
16:29:10 25 is that correct, Helen?

16:29:11 26 A. Well, I know, you know, some
16:29:13 27 of the phrases that I used with Bethe, and I
16:29:17 28 feel that is what I was telling the College.

16:29:25 29 MR. SANDLER: Well, I have made
16:29:26 30 an objection, Commissioner, and
16:29:27 31 I am not quite sure --

16:29:29 32 THE COMMISSIONER: I'm sorry,

16:29:30 1 this is what the clarification
16:29:31 2 is and what I understand the
16:29:33 3 witness now to be saying is that
16:29:34 4 she had standard practice in the
16:29:37 5 language she would use, and
16:29:39 6 therefore, she is reflecting on
16:29:40 7 her standard practice in terms
16:29:42 8 of what is reflected in that.
16:29:45 9 MR. SANDLER: All right. But as
16:29:48 10 I say, I don't know what this
16:29:50 11 evidence is going to be in
16:29:51 12 advance, so that is -- but in
16:29:54 13 any event...
16:29:55 14 THE COMMISSIONER: Well, why
16:29:56 15 don't we --
16:29:57 16 MS. HEWITT: Well, my friend
16:29:58 17 will be entitled to
16:29:59 18 cross-examine. We are not going
16:30:01 19 to get to cross-examinations
16:30:02 20 today, so he'll know today what
16:30:06 21 the evidence will be. I'm not
16:30:09 22 sure --
16:30:10 23 THE COMMISSIONER: Okay, I tell
16:30:11 24 you, why don't we let it go a
16:30:14 25 little further. That is what I
16:30:15 26 understood. You are right, she
16:30:16 27 said I don't have an independent
16:30:17 28 recollection, but when Ms.
16:30:21 29 Hewitt went back after your
16:30:22 30 objection, what I heard her to
16:30:24 31 say was I had standard language
16:30:25 32 that I used when I was speaking

16:30:29 1 with Elizabeth Wettlaufer, so
16:30:31 2 when I reviewed these notes, I
16:30:32 3 expected to see my standard
16:30:34 4 language coming up there.
16:30:36 5 So at this point what I would do
16:30:38 6 is I would let the witness go
16:30:39 7 ahead, see where we are going
16:30:41 8 with the questioning, and if
16:30:42 9 there is a problem, you stand up
16:30:43 10 and object again.

16:30:45 11 THE WITNESS: All right. So
16:30:46 12 where it says "she started
16:30:49 13 working evening shifts," you
16:30:54 14 know, the word "also" is missing
16:31:01 15 because before that she worked
16:31:03 16 night shifts as well, and she
16:31:04 17 was the only registered staff.

16:31:07 18 BY MS. HEWITT:

16:31:07 19 Q. Sorry, that --

16:31:08 20 A. A Registered Nurse, you know,
16:31:10 21 there was an RPN.

16:31:16 22 And then somewhere about where
16:31:20 23 "she was nice," you know, it was "to me" I
16:31:24 24 thought the words were missing, "she was always
16:31:27 25 nice to me."

16:31:28 26 Q. Sorry, let's just find out
16:31:29 27 where you are. How many bullet points down are
16:31:31 28 you referring to?

16:31:39 29 A. It was the last line
16:31:41 30 actually:

16:31:41 31 "She was always respectful and
16:31:42 32 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

1 else, Helen, or would you like to break now?

2 A. Well, again, I want to say
3 I'm so sorry that it happened.

4 MR. HEWITT: Okay, those are my
5 questions.

6 THE COMMISSIONER: Thank you.
7 Thank you so much.

8 THE WITNESS: Thank you.

9 THE COMMISSIONER: We are going
10 to finish now, and I know that
11 it is hard, but part of it --
12 you have made me upset too --
13 part of the Public Inquiry is to
14 let people hear that.

15 THE WITNESS: And that is why
16 I'm here, because I hope it does
17 improve the system so that care,
18 you know, will be what a good
19 nurse expects for her residents.

20 THE COMMISSIONER: Yes, and that
21 is true, that is what this is
22 about, but what I am explaining
23 is that part of this is for
24 everybody who has been harmed
25 through the process, including
26 you.

27 So as hard as it is, I hope that
28 you find that there is some
29 closure to the events by being
30 able to publicly explain your
31 feelings and to assist us with
32 our fact-finding process.

16:39:03 1 So I wanted to just let you know
16:39:05 2 how much we appreciate it. We
16:39:07 3 know how hard it must be for
16:39:09 4 you. So thank you.
16:39:10 5 THE WITNESS: Thank you.
16:39:12 6 MS. HEWITT: Thank you,
16:39:13 7 Commissioner. So obviously,
16:39:14 8 there is some cross-examinations
16:39:17 9 that will continue on Monday.
16:39:20 10 Mr. Sandler has indicated that
16:39:21 11 perhaps we should mark Ms. Yee's
16:39:24 12 statement as an exhibit and I am
16:39:26 13 probably going to get chastised
16:39:28 14 by our document person as soon
16:39:29 15 as we leave because I probably
16:39:31 16 should have made anything that
16:39:32 17 wasn't in the exhibit -- or in
16:39:34 18 the affidavit an exhibit.
16:39:36 19 So I'm at your mercy. We could
16:39:39 20 make everything --
16:39:40 21 THE COMMISSIONER: I think all
16:39:41 22 the documents that were not
16:39:43 23 marked as exhibits, and there
16:39:44 24 were not that many of them, are
16:39:46 25 in the database and in the ORs,
16:39:49 26 and the only reason that there
16:39:50 27 is a gap and we are having to
16:39:52 28 deal with this is because there
16:39:55 29 is a gap for the public and
16:39:57 30 those documents are going to be
16:39:58 31 coming up. In my view, the
16:40:01 32 transcript can be followed

16:40:03 1 without marking those, and there
16:40:05 2 are very few, and it is late in
16:40:07 3 the day.
16:40:07 4 So in my view, we will leave it
16:40:09 5 at this stage. If anybody has
16:40:10 6 the view that the public is
16:40:12 7 either not able to follow it or
16:40:13 8 whatever, I will on Monday
16:40:15 9 morning, the first thing we'll
16:40:17 10 do is we'll put the documents
16:40:18 11 in.
16:40:19 12 MR. SANDLER: I respectfully
16:40:21 13 just want to say to you,
16:40:26 14 Commissioner, first of all it
16:40:27 15 turned out that my objection was
16:40:28 16 all for naught, and not that you
16:40:30 17 need to --
16:40:30 18 THE COMMISSIONER: Call it the
16:40:31 19 Commissioner's intuition,
16:40:32 20 Mr. Sandler.
16:40:34 21 MR. SANDLER: It turned out to
16:40:37 22 be much ado about not much. But
16:40:40 23 what I am concerned about is the
16:40:42 24 witness has effectively adopted
16:40:44 25 the balance of the statement and
16:40:47 26 the public has no way of seeing
16:40:49 27 the balance, they have only
16:40:51 28 heard what she has described.
16:40:52 29 And I am concerned about it
16:40:53 30 simply because I would like the
16:40:54 31 public, or the media if they are
16:40:56 32 reporting on that story, to see

16:40:57 1 the full report.

16:40:58 2 THE COMMISSIONER: The report by

16:41:02 3 Inspector Yee you are talking

16:41:05 4 about from the College?

16:41:07 5 MR. SANDLER: Yes.

16:41:07 6 THE COMMISSIONER: It was up on

16:41:08 7 the screen.

16:41:08 8 MR. SANDLER: Well, it was up on

16:41:09 9 the screen, but nobody had the

16:41:11 10 opportunity to read that on the

16:41:13 11 screen, it momentarily flashed,

16:41:16 12 that is all I'm saying.

16:41:17 13 THE COMMISSIONER: It does go

16:41:19 14 through on the website, and the

16:41:21 15 webcast is available to go back

16:41:22 16 and look at. Is that of any

16:41:24 17 comfort? I mean, if I watch the

16:41:26 18 webcast and I want to stop and

16:41:29 19 go back, I can go back and look.

16:41:32 20 MR. SANDLER: I wasn't sure that

16:41:33 21 the full document was projected

16:41:37 22 with both of its pages, but --

16:41:40 23 MS. HEWITT: I think --

16:41:42 24 MR. SANDLER: If you tell me it

16:41:43 25 was...

16:41:43 26 THE COMMISSIONER: Well, I mean,

16:41:44 27 that is my understanding. Part

16:41:45 28 of the reason of why I'm doing

16:41:47 29 my recordkeeping and everything

16:41:49 30 the way I am is I am trying to

16:41:51 31 position myself exactly like a

16:41:53 32 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 1 identified by the maker.

16:42:53 2 THE COMMISSIONER: True, but

16:42:53 3 they are already produced and

16:42:55 4 therefore part of the exhibit,

16:42:56 5 and so in my view, we don't have

16:42:58 6 to have them identified by the

16:43:00 7 maker, right, because they are

16:43:01 8 part of another one.

16:43:02 9 MS. HEWITT: Right.

16:43:02 10 MR. SANDLER: Thank you,

16:43:04 11 Commissioner, that is fine.

16:43:05 12 THE COMMISSIONER: Yeah, so I

16:43:06 13 think that is not a difficulty

16:43:07 14 at all. So --

16:43:12 15 MS. HEWITT: I don't have a

16:43:13 16 clean copy. This is

16:43:15 17 Mr. Golden's.

16:43:15 18 MR. SANDLER: We do.

16:43:16 19 THE COMMISSIONER: All right.

16:43:20 20 So do you by chance have two

16:43:22 21 clean copies because I would

16:43:24 22 like just to make sure that I

16:43:25 23 have a full record up here as

16:43:27 24 well?

16:43:27 25 MR. SANDLER: Yes.

16:43:39 26 MS. HEWITT: Here is one, and

16:43:40 27 two. Thank you, Madam Clerk.

16:43:50 28 THE COMMISSIONER: Thank you so

16:43:51 29 much. So just to check, by my

16:43:55 30 notes, is that Exhibit 17, Madam

16:44:00 31 Clerk?

16:44:00 32 THE COURT CLERK: That is

16:44:01 1 correct.

16:44:01 2 THE COMMISSIONER: Exhibit 17

16:44:02 3 then is a document, a two-page

16:44:12 4 document beginning with the

16:44:14 5 words "Name of contact Helen

16:44:16 6 Crombez DON, date of contact

16:44:22 7 July 30, 2014," responded to by

16:44:24 8 Karen Yee, Intake Investigator.

16:44:27 9 And that is also in the

16:44:29 10 documents at document number

16:44:32 11 36847.

16:44:36 12 EXHIBIT NO. 17: Interview

16:44:36 13 summary by Intake Investigator

16:44:38 14 Karen Yee.

16:44:38 15 THE COURT CLERK: And

16:44:39 16 Commissioner, the title of the

16:44:40 17 exhibit should be?

16:44:41 18 THE COMMISSIONER: Interview

16:44:42 19 summary by telephone.

16:44:43 20 THE COURT CLERK: Thank you.

16:44:44 21 THE COMMISSIONER: Thank you.

16:44:45 22 All right. So is there anything

16:44:54 23 else then that needs to be done

16:44:57 24 before we convene for the

16:44:59 25 weekend?

16:45:02 26 MS. HEWITT: I don't see anybody

16:45:03 27 rushing to their feet,

16:45:05 28 Commissioner.

16:45:05 29 THE COMMISSIONER: I think

16:45:06 30 everybody has had a long week,

16:45:07 31 and I thank everyone for their

16:45:09 32 patience and consideration

16:45:11 1 throughout.
16:45:11 2 It has been exemplary.
16:45:14 3 So we will start at 9:30 on
16:45:17 4 Monday. Will I get an email at
16:45:19 5 all with some indication of the
16:45:21 6 order in which examinations and
16:45:23 7 cross-examinations will take
16:45:24 8 place?
16:45:24 9 MS. HEWITT: We can arrange
16:45:26 10 that. Does anyone know whether
16:45:28 11 they are switching times or
16:45:30 12 sequence? Yes, we can arrange
16:45:32 13 to send you that email. It
16:45:33 14 would be Mr. Golden would be
16:45:35 15 entitled to ask questions first.
16:45:36 16 THE COMMISSIONER: Right.
16:45:37 17 MS. HEWITT: And then the
16:45:38 18 sequence would go from there.
16:45:39 19 The families would be up next.
16:45:42 20 THE COMMISSIONER: Okay, thank
16:45:43 21 you.
16:45:44 22 All right. Then with that in
16:45:47 23 mind, as I am just going to
16:45:50 24 remind you, they are going to
16:45:51 25 come in to clean the courtroom,
16:45:53 26 so if you do have anything in
16:45:54 27 here, you may want to remove it.
16:45:57 28 But everybody can leave their
16:45:59 29 name tags and stuff, right?
16:46:01 30 Their name plates?
16:46:04 31 All right, thank you very much
16:46:05 32 all.

16:46:05

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-- 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



NEESON COURT REPORTING INC.

PER: DEANA SANTEDICOLA, RPR, CRR, CSR
CERTIFIED REAL-TIME REPORTER

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