PUBLIC INQUIRY INTO THE SAFETY AND SECURITY OF RESIDENTS IN THE LONG-TERM CARE HOMES SYSTEM

OVERVIEW REPORT: OFFICE OF THE CHIEF CORONER AND THE ONTARIO FORENSIC PATHOLOGY SERVICE

June 5, 2018

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TAB A:
SPECIFIC CHRONOLOGY

Overview Report:
Office of the Chief Coroner and the Ontario Forensic Pathology Service

SUMMARY

The Chronology below outlines the involvement of the Office of the Chief Coroner (the "**OCC**") and the Ontario Forensic Pathology Service (the "**OFPS**") (collectively, the "**OCC/OFPS**"), and local coroners, in the events surrounding the Offences committed by Elizabeth Wettlaufer ("**EW**").

Pursuant to s. 10(2.1) of the *Coroners Act*, R.S.O. 1990, c. C.37 (the "*Coroners Act*"), where a person dies while resident in a long-term care home, the person in charge of the home is required to "immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation, he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body."

Of EW's eight murder victims, the OCC has located, in its files, six Institutional Patient Death Records ("**IPD Records**"). With respect to Gladys Millard, Caressant Care's records contain an IPD Record with the handwritten note "FAXED 10/14/11 JL", but OCC has been unable to locate a copy in its files. With respect to Arpad Horvath, his death occurred in a hospital, and therefore no IPD Record was required or submitted.

IPD Records contain a series of questions "intended to help determine if a local coroner should be contacted". If any of the questions are answered "Yes", a local coroner must be contacted directly and immediately.

Local coroners were contacted regarding the deaths of one of EW's murder victims (James Silcox), and one of EW's attempted murder victims (Wayne Hedges, when Mr. Hedges later passed away) as a result of questions answered "Yes" on their respective IPD Records. In the case of James Silcox, the questions answered "Yes" were that the death was accidental and that it was both sudden and unexpected. In the case of Wayne Hedges, the questions answered "Yes" were that there had been a recent increase in the number of deaths at the Nursing home and it was also a threshold case, or the 10th death in the home. Local coroners then attended to investigate the two deaths.

It appears that a local coroner was also contacted in relation to Maureen Pickering's death (although all questions on the IPD Record were answered "No"), because of a recommendation made by the Woodstock Hospital Emergency Physician who had treated Ms. Pickering five days earlier in the Hospital, but the local coroner declined to investigate the death.

After EW's confession, post mortem examinations were performed on the bodies of two of the victims, namely Arpad Horvath and Helen Matheson. Post mortem examinations were not possible for the six other murder victims who had been cremated. The OCC/OFPS conducted "retrospective investigations" of each of the eight deaths with respect to which EW was convicted of murder. In respect of the six additional victims (those with respect to whom EW was convicted of aggravated assault or attempted murder), the Chief Pathologist of Ontario reviewed the medical records to attempt to correlate the statement of EW with medically-documented episodes of hypoglycemia.

CHRONOLOGY

	DATE	EVENT
1.	August 12, 2007	EW charted that she found James Silcox without vital signs at 03:55 at Caressant Care. EW completed and submitted an IPD Record to the OCC by fax at or around 0500. EW checked "Yes" to two of the ten questions on the IPD Record: (1) accidental death and (5) death both sudden and unexpected. At 05:15, the local coroner, Dr. William George ("**Dr. George**") was notified of the case. Dr. George attended at Caressant Care at approximately 06:45, formally pronounced James Silcox dead at 07:00, and completed a Medical Certificate of Death – Form 16 (a "**Medical Certificate of Death**"). On the Medical Certificate of Death, Dr. George identified the immediate cause of death as "complications of fractured right hip", and other significant conditions as "Alzheimer's, diabetes, cerebrovascular disease". Dr. George also completed a Coroner's Investigation Statement (Form 3) for James Silcox on or about September 10, 2007, mirroring the above information, and indicating that Mr. Silcox was: "last seen alive at 02:00 hours by the nursing staff on rounds. He was found unresponsive with vital signs absent at 03:55 hours […] His death was a result of complication following a fall in which he sustained a right hip fracture".
2.	December 23, 2007	Following Maurice Granat's death at Caressant Care, Frances Crown (position at Caressant Care not indicated) completed and submitted an IPD Record to the OCC at or around 11:35. Each of the 10 questions on the IPD Record was answered "No".
3.	January 24, 2009	Following Wayne Hedge's death at Caressant Care at 08:05, Jennifer Hague, RN completed and submitted an IPD Record to the OCC, which was received at 09:15. Two of the ten questions on the IPD Record were answered "Yes": (7) an increase in the number of deaths at the nursing home and (10) threshold case.

	DATE	EVENT
		Dr. Elizabeth Urbantke ("**Dr. Urbantke**"), a local coroner, issued a Warrant to Take Possession of the Body of a Deceased Person for Wayne Hedges.
4.	January 30, 2009	The Case Notification Form of a new Coroner's Investigation Death re: Wayne Hedges was completed by Dr. Urbantke and sent to the Regional Supervising Coroner's office. The preliminary cause of death was listed as "CVA", and noted under any other information was: "10th death, 3rd in 24 hours". Dr. Urbantke subsequently completed a Coroner's Investigation Statement (Form 3) relating to Wayne Hedges. The medical cause of death was listed as a cerebrovascular accident, with a contributing factor of diabetes. The Form 3 indicated that this death "was the threshold death for the nursing home" and the case "was accepted as such". The Form 3 also noted that "[t]wo days prior to death the deceased was noted to have a decreased level of consciousness and inability to swallow with unilateral drooling. It was felt he had had another cerebrovascular accident. The family and physician were notified. Comfort measures were undertaken. Death was pronounced by the on call physician at 08:05 on 24 January 2009. The cause of death was cerebrovascular accident. Family had no concerns. Review of the previous deaths revealed no concerns. Coroners had been informed of deaths during an outbreak".
5.	October 14, 2011	Following Gladys Millard's death at Caressant Care at 16:00, Janette Langsford, RPN, completed and submitted an IPD Record to the OCC by fax. The OCC cannot currently locate a copy of this document. Each of the ten questions on the IPD Record was answered "No".
6.	October 27, 2011	Following Helen Matheson's death at Caressant Care at 01:00, Nurse Durbidge, RN completed and submitted an IPD Record to the OCC by fax. Each of the 10 questions on the IPD Record was answered "No".
7.	November 7, 2011	Following Mary Zurawinski's death at Caressant Care (time not specified), Suzanne Kungl, RN completed and submitted an IPD Record to the OCC by fax.

	DATE	EVENT
		Each of the 10 questions on the IPD Record was answered "No".
8.	July 14, 2013	Following Helen Young's death at Caressant Care at 08:40, Agatha Krawczyk, RN completed and submitted an IPD Record to the OCC online at approximately 13:10. Each of the 10 questions on the IPD Record was answered "No".
9.	March 23, 2014	At 11:46, Maureen Pickering was admitted to Woodstock Hospital (from Caressant Care), under attending physician Dr. Urbantke. Maureen Pickering's final diagnosis was "severe hypoglycemia". At 17:11, EW documented a progress note for Maureen Pickering in the Caressant Care chart, which included: "Received call from Dr. Urbantke from Woodstock Hospital at 17:00. Maureen continues to be unresponsive and tests show the possibility of a "mid brain" stroke. Maureen will be coming back to us this evening in a palliative state. Orders received for comfort measures only, hold all p.o. meds, Ativan sub q prn and hydromorph sub q prn". At 17:21, EW documented another progress note, which included: "Dr. Urbantke mentioned that Maureen's blood sugar was extremely low when she arrived at the hospital and the cause is unknown. She stated that if Maureen passes it "might be a good idea to call the coroner on this one"."
10.	March 28, 2014	Following Maureen Pickering's death at Caressant Care at 09:15, Karen Routledge, RN contacted the local coroner, Dr. George at 09:30. At 09:35, Nurse Routledge completed and submitted an IPD Record online. Each of the 8 questions on the IPD Record was answered "No". At 09:23 (and onwards), Nurse Routledge documented notes relating to Maureen Pickering, which included: "Found deceased with no respirations or pulse. Friend Don Tuck called and body is to be released to Ostrander Funeral Home in Tillsonburg. As per recommendation by WH emerg physician Dr. Urbantke the coroner on call was notified. 09:50 – Dr. George called back and did not feel this was a coroner's case. Dr. Reddick called by page and in to pronounce at 10:35. Ostranger FH contacted and body released at 11:25".

	DATE	EVENT
11.	September 22, 2016	Local Coroner Dr. George called and spoke to Regional Supervising Coroner for West Region – London, Dr. G. Rick Mann ("**Dr. Mann**") to report that he had been contacted by the police to discuss the death of Mr. Silcox, in order to "[give us] head's up".
12.	October 27, 2016	Dr. Mann signed *Coroner's Authority to Seize During an Investigation* forms in respect of the eight murder victims and sent them to Caressant Care and Meadow Park. On November 15, 2016, Dr. Mann sent a letter to Helen Crombez, Director of Nursing at Caressant Care, confirming further to an earlier telephone call in November 2017 [sic] that she did not need to act upon the *Coroner's Authority to Seize* dated October 27, 2016 at that time. On December 28, 2016, Dr. Mann wrote to Nicole Ross, Administrator of Meadow Park London, indicating that she could disregard the *Coroner's Authority to Seize During an Investigation* dated October 27, 2016 that was sent regarding the death of Arpad Horvath.
13.	November 2016	Communications took place between the OCC and the Horvath family.
14.	November 1, 2016	The Regional Coroner's Office – West Region (London Office) delivered a Records Retrieval Request re: J. Silcox to the Office of the Chief Coroner. The Regional Coroner's Office was advised that the file was not in the box.
15.	November 3, 2016	Dr. Michael S. Pollanen, Chief Forensic Pathologist for Ontario ("**Dr. Pollanen**"), met with Assistant Crown Attorney Fraser Kelly ("**Mr. Kelly**") and members of the OCC, including the Chief Coroner, and Ontario Provincial Police ("**OPP**"). During this meeting, Dr. Pollanen was briefed about the (then) alleged murder of eight people in long-term care by EW. Dr. Pollanen was asked to undertake a medical review of the eight cases for which EW had confessed to murder and to determine if exhumations were warranted.
16.	November 4, 2016	Dr. Pollanen's office received the medial records pertaining to the eight deceased patients from the OPP. Further exchanges between Dr. Pollanen and Detective Hagerman of the OPP re: outstanding medical records and

	DATE	EVENT
		cremation/burial information took place over the following ten days.
17.	November 10, 2016	Local Coroner Dr. George called and left a message for Dr. Mann reporting that the police had come and spoken to him "about NH death (one of the ones being investigated). He had his notes & was able to provide them c info".
18.	November 9 and 11, 2016	Dr. Pollanen emailed Dr. Jeffrey Jentzen, a forensic pathologist in Michigan, to inquire whether he would be available to conduct a peer review of his report. On November 11, 2016, Dr. Jentzen confirmed his availability to assist.
19.	November 16, 2016	Dr. Pollanen met with members of the Crown and OPP and gave a presentation on his preliminary review of the eight cases then under review. The PowerPoint presentation included information about insulin, glucose, and circumstantial, medical and scientific evidence of fatal insulin-induced hypoglycemia. Each of the eight cases was also reviewed. Dr. Pollanen's preliminary conclusions included: • "(1) In none of the eight cases can the cause of death be medically and scientifically proven to be due to the administration of insulin because autopsies and insulin testing was not conducted in any case. • (2) Maureen Pickering died of the effects of hypoglycemia, which corroborates Wettlaufer's statement. • (3) Arpad Horvath died of natural causes. Insulin did not play a role in his death. • (4) In the other six cases, I am medically undecided about the role of insulin in contributing to death because the medical data is not complete enough to support or refute Wettlauffer's [sic] statement. • (5) The body of Helen Matheson should be exhumed for autopsy to determine if hypoglycemic encephalopathy is present and to determine cause of death, if possible." Dr. Pollanen also emailed the PowerPoint presentation to Detective Hagerman, and asked Detective Hagerman for any and all medical records that the OPP had on the eight cases discussed.

	DATE	EVENT
20.	November 17, 2016	Mr. Kelly requested Dr. Pollanen's written opinion on disinterment, specifically: "in [Dr. Pollanen's] opinion, will the [sic] disinterring the remains or Arpat [sic] Horvath and/or Maureen Pickering [sic] for autopsy afford evidence with respect to the commission of murder or attempted murder? If so (or not), why?"
21.	November 17, 2016	Dr. Pollanen completed a letter to Mr. Kelly regarding the disinterment of the bodies of Arpad Horvath and Helen Matheson. Dr. Pollanen reported that, in his view, "substantial medical/scientific evidence of murder or attempted murder could be gained if the bodies of Matheson and Horvath were exhumed and autopsies were conducted". He noted that examination of the brains particularly may ascertain whether hypoglycemic brain damage was present. Dr. Pollanen's ultimate conclusion was that: "in the interest of seeking truth behind the deaths of Horvath and Matheson, exhumation and autopsy must occur. There is a reasonable basis to believe, based on medicine and science, that exhumation and autopsy may reveal evidence that could corroborate that the deaths of Horvath and Matheson are related to murder, or that either or both incurred brain damage from attempted murder."
22.	November 28 to December 7, 2016	On November 28, 2016, Dr. Pollanen emailed a copy of his report to Dr. Jentzen and Dr. Christopher Milroy ("**Dr. Milroy**"), a staff forensic pathologist at The Ottawa Hospital and a registered forensic pathologist at the OFPS respectively, for peer review. On November 29, 2016, Dr. Roland Auer, a neuropathologist at the University of Saskatchewan, agreed to consult for the case at Dr. Pollanen's request. On December 7, 2016, Dr. Jentzen reported the results of his review to Dr. Pollanen. He indicated that he had "no significant comments" and suggested minor revisions to the report. Dr. Jentzen confirmed his agreement that "the Pickering case is consistent with insulin toxicity" and indicated that he otherwise agreed with the report.
23.	December 2-3, 2016	Mr. Kelly emailed Dr. Pollanen, inquiring whether there was a way to determine if living patients suffered brain damage due to severe hypoglycemia.

	DATE	EVENT
		On December 3, 2016, Dr. Pollanen responded to confirm that he would need to review all available medical records on the six survivors to be able to suggest what could be done medically to determine (if possible) if hypoglycemic brain damage occurred.
24.	December 6, 2016	Dr. Urbantke called and left a message for Dr. Mann, reporting that she had been advised by the Ministry of Long-term Care the previous day that she had seen Maureen Pickering in the emergency room, and that when she was transferred to Palliative Care Dr. Urbantke had advised to have a coroner called when Maureen Pickering died as she had an unexpected hypoglycemia. The coroner who was called declined the case.
25.	December 8, 2016	Dr. Pollanen's report dated December 1, 2016 and entitled: "Initial Report of the Medical Investigation Into Eight Elderly People Who Died Under the Care of Elizabeth Wettlauffer" [sic], is delivered to Mr. Kelly. Dr. Pollanen's initial conclusions included that: (1) Maureen Pickering died of the effects of hypoglycemia; and (2) he was undecided about the role of insulin in causing death in the other cases.
26.	January 11, 2017	Dr. Mann emailed Joanne Whitney at the Coroner's Office Provincial Dispatch further to the logistical arrangements for the exhumations of the bodies of Arpad Horvath and Helen Matheson, then planned to occur on January 24, 2017.
27.	January 12, 2017	The OCC/OFPS were assigned the Helen Matheson and Arpad Horvath exhumations. The Case Information sheet for each indicated that: "The OPP are planning to exhume 2 bodies on January 24, 2017 from the 8 Woodstock Nursing Home", and that autopsies had been ordered.
28.	January 20, 2017	Dr. Mann completed Warrants for Post Mortem Examination and Warrants to Take Possession of the Body of a Deceased Person in relation to Arpad Horvath and Helen Matheson.

	DATE	EVENT
		The Warrants for Post Mortem Examination: • Described the circumstances of death as: "Part of investigation of 8 Nursing Home deaths in Southwestern Ontario. Investigative information raised significant concern of Insulin toxicity. Body exhumed." • Described the reason for post mortem examination as: "Establish cause of death."
29.	January 22, 2017	Dr. Pollanen was contacted by Mike Shkrum, who advised that Brad Burgess (defence counsel for EW) had requested he attend the autopsies.
30.	January 26, 2017	Dr. Pollanen performed an autopsy of the bodies of Arpad Horvath and Helen Matheson. Dr. Pollanen requested neuropathology consults, and emailed Dr. Mann his preliminary views from the autopsies, noting in both cases that the cause of death was pending.
31.	January 27, 2017	Mr. Kelly emailed Dr. Pollanen regarding whether a neuropathologist would become involved in the case. Mr. Kelly also requested confirmation that Dr. Pollanen could have a written opinion within three months. Dr. Pollanen responded to confirm this information.
32.	February 1, 2017	Marie Elliot at Centre of Forensic Sciences called Dr. Mann re: toxicology testing of Arpad Horvath and Helen Matheson.
33.	February 7, 2017	Mr. Kelly emailed Dr. Pollanen to advise him that six new charges were laid against EW and that he had requested the police assemble and deliver the related medical records for Dr. Pollanen's review and comment.
34.	February 8, 2017	Dr. Pollanen appears to have begun a draft report to Mr. Kelly re: R v Wetlauffer [sic] – the 'living' cases.
35.	February 22, 2017	Detective Sergeant Kevin Talsma provided Dr. Pollanen additional medical records for his review pertaining to the six additional cases (C. Adriano, A. Demedeiros, W. Hedges, M. Priddle, S. Towler, B. Bertram), as well as additional medical records of A. Horvath and statements made by EW.

	DATE	EVENT
36.	February 28, 2017	Dr. Kristopher S. Cunningham, a forensic and cardiovascular pathologist ("**Dr. Cunningham**") completed cardiovascular examination reports for the postmortem examinations of Arpad Horvath and Helen Matheson
37.	March 13, 2017	Dr. A. Ramsay ("**Dr. Ramsay**"), a neuropathologist, completed neuropathology consultation reports for the postmortem examinations of Arpad Horvath and Helen Matheson. In respect of Arpad Horvath, Dr. Ramsay's ultimate conclusion was that: "the neuropathological examination has not provided definitive evidence of a hypoglycemic encephalopathy although, as discussed, there are several clinical and pathological findings that, when taken together, are suggestive of this diagnosis." In respect of Helen Matheson, Dr. Ramsay's ultimate conclusion was that: "[t]he tissue is not well enough preserved to assess whether or not there are the acute or chronic histological and immunohistochemical changes that may be associated with hypoxic-ischemic and/or hypoglycemic brain injury." Dr. Pollanen received copies of Dr. Ramsay's neuropathology consultation reports on March 14, 2017.
38.	May 3 to 20, 2017	Mr. Kelly and Dr. Pollanen exchanged emails pertaining to the timing of completion of Dr. Pollanen's reports and the contents of the agreed statement of fact.
39.	May 4, 2017	An OFPS Peer Review Form was completed by Dr. Milroy, the reviewing pathologist, regarding Dr. Pollanen's postmortem examination reports for Arpad Horvath and Helen Matheson. Dr. Milroy reviewed the postmortem examination reports and photographs and confirmed, among other things, that the cause of death set out in the reports were reasonable.
40.	May 8, 2017	Dr. Pollanen completed the Postmortem Examination Reports of Arpad Horvath and Helen Matheson. His ultimate conclusion was that the cause of death in both cases was undetermined.

	DATE	EVENT
		In relation to Arpad Horvath, Dr. Pollanen concluded that the sequence of events leading to death started with hypoglycemia, which could have caused coma and could corroborate the putative administration of insulin. He concluded that hypoglycemic encephalopathy was a possible cause of death, but that the neuropathologic evidence was only suggestive, not definitive. Overall: "based on the limitation of the autopsy and lack of insulin testing at the time of the initial hypoglycemic episode, the cause of death is undetermined." In relation to Helen Matheson, Dr. Pollanen reported that the body was too decomposed to determine the cause of death, noting that it could have been due to endometrial carcinoma and Alzheimer's disease. Dr. Pollanen reported that body was too decomposed to determine if any findings were present that could corroborate the history of non-therapeutic insulin administration.
41.	May 25, 2017	Dr. Pollanen prepared a report to Mr. Kelly based on his review of the six additional cases to "correlate the statement of EW (in which she claims to have covertly administered insulin) with medically-documented episodes of hypoglycemia" (cases: M. Priddle, B. Bertram, A. Demedeiros, W. Hedges, S. Towler, C. Adriano). Dr. Pollanen's conclusion included that: "there is no definite medical evidence that hypoglycemic episodes were caused by the administration of insulin in any of the patients, as claimed by EW", because no insulin testing was conducted at the relevant times.
42.	January 22, 2018	Print Date of Coroner's Investigation Statements (Form 3) by Dr. Mann relating to: • Maurice Granat (status: preliminary) • Gladys Millard (status: preliminary) • Helen Young (status: preliminary) • Mary Zurawinski (status: preliminary)
43.	February 8, 2018	Print Date of Coroner's Investigation Statement (Form 3) by Dr. Mann relating to: • Arpad Horvath (status: preliminary) • Helen Matheson (status: preliminary)

	DATE	EVENT
44.	February 9, 2018	Print Date of Coroner's Investigation Statement (Form 3) relating to Maurice Granat (status: final) by Dr. Dirk W. Huyer, the Chief Coroner for Ontario ("**Dr. Huyer**"), based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "hypoglycemia", due to / as a consequence of: "inrtentional [sic] administration of exogenous insulin". In the Form 3, Dr. Huyer notes that "the death was not investigated by a Coroner at the time of death. Mr. Granat's body was cremated preventing potential post-mortem examination." Dr. Huyer concludes that: "based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as hypoglycemia due to administration of exogenous insulin with the manner provided as homicide."
45.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to Arpad Horvath (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "complications of hypoglycemia" due to / as a consequence of: "administration of exogenous insulin" with a contributing factor: "diabetes". In the Form 3, Dr. Huyer cites the pathologist's conclusion that the cause of death was undetermined, and concludes that: "[b]ased upon the information provided by Ms. Wettlaufer and that documented medically clinicopathologic correlation leads to the cause of death being provided as complications of hypoglycemia. The manner is provided as homicide due to administration of exogenous insulin with the manner provided as homicide".
46.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to Helen Matheson (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "complications of hypoglycemia" due to / as a consequence of: "administration of exogenous insulin" with a contributing factor: "endometrial carcinoma". In the Form 3, Dr. Huyer cited the pathologist's conclusion that the cause of death was undetermined due to the limitation of the autopsy, and concluded that: "[b]ased upon the information provided by Ms. Wettlaufer and that

	DATE	EVENT
		documented medically clinicopathologic correlation leads to the cause of death being provided as complications of hypoglycemia. The manner is provided as homicide due to administration of exogenous insulin with the manner provided as homicide."
47.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to Gladys Millard (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "hypoglycemia" due to / as a consequence of "intentional administration of exogenous insulin". In the Form 3, Dr. Huyer concluded that: "[b]ased on the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide."
48.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to Maureen Pickering (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "complications of hypoglycemia" due to / as a consequence of: "administration of exogenous insulin". In the Form 3, Dr. Huyer concluded that: "[b]ased on the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide."
49.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to James Silcox (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "hypoglycemia" due to / as a consequence of: "intentional administration of exogenous insulin" with contributing factors: "dementia, diabetes, cerebrovascular disease". In the Form 3, Dr. Huyer noted: "The death was investigated by a coroner at the time of death. The coroner was contacted given the potential relationship between recent hip fracture and death. The coroner provided his opinion that

	DATE	EVENT
		the death resulted from complications of hip fracture with the manner provided as accident. He noted that there were no signs of traumatic injury. The deceased person was cremated eliminating the potential for post mortem examination. Based on the additional information the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide".
50.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to Helen Young (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "hypoglycemia" due to / as a consequence of: "administration of exogenous insulin". In the Form 3, Dr. Huyer noted: "The death was not investigated by a coroner at the time of death. Ms. Young's body was cremated preventing potential post mortem examination. Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide".
51.	February 9, 2018	Print Date of Coroner's Investigation Form (Form 3) relating to Mary Zurawinski (status: final) by Dr. Huyer, based on a retrospective investigation by the OCC/OFPS. Medical cause of death: "hypoglycemia" due to / as a consequence of: "intentional administration of exogenous insulin". In the Form 3, Dr. Huyer noted: "[t]he death was not investigated by a coroner at the time of death. Ms. Zurawinski's body was cremated preventing potential post mortem examination. Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide."

TAB B:
SOURCE DOCUMENTS FOR SPECIFIC CHRONOLOGY

Overview Report:
Office of the Chief Coroner and the Ontario Forensic Pathology Service

Event/Tab numbers correspond to numbered Events in the Chronology.

Source Document names may differ from those in the Database, as some names have been amended for clarity.

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
1.	• Caressant Care Progress Notes re: James Silcox completed by EW dated August 12, 2007	LTCI00065225 p. 1
	• Medicate Certificate of Death – Form 16 re: James Silcox completed by Dr. George dated August 12, 2007	LTCI00065226 p. 6
	• Caressant Care Resident Death Form re: James Silcox completed by EW dated August 12, 2007	LTCI00065226 p. 122
	• IPD Record re: James Silcox completed by EW dated August 12, 2007	LTCI00065226 p. 123
	• Coroner's Investigation Statement (Form 3) re: James Silcox completed by Dr. George	LTCI00065227 p. 1-2
2.	• IPD Record re: Maurice Granat dated December 23, 2007	LTCI00064904 p. 6
3.	• IPD Record re: Wayne Hedges dated January 24, 2009	LTCI00064920 p. 4
	• Warrant to Take Possession of the Body of Deceased Person re: Wayne Hedges completed by Dr. Urbantke	LTCI00064920 p. 6
4.	• Case Notification Form re: new Coroner's Investigation Death re: Wayne Hedges completed by Dr. Urbantke	LTCI00064920 p. 5
	• Coroner's Investigation Statement (Form 3) re: Wayne Hedges completed by Dr. Urbantke	LTCI00064920 p. 1
5.	• IPD Record re: Gladys Millard dated October 14, 2011	LTCI00003479 p. 4
6.	• IPD Record re: Helen Matheson dated October 27, 2011	LTCI00065195

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
7.	• IPD Record re: Mary Zurawinski dated November 7, 2011	LTCI00065247 p. 7
8.	• IPD Record re: Helen Young dated July 14, 2013	LTCI00065236 p. 284
9.	• Caressant Care Progress Notes re: Maureen Pickering completed by EW dated October 23, 2014	LTCI00065222 p. 2-3
	• Woodstock Hospital Emergency Record completed by Dr. Urbantke dated October 23, 2014	LTCI00065223 p. 85
10.	• Caressant Care Progress Notes re: Maureen Pickering dated October 28, 2014	LTCI00065222 p. 1
	• IPD Record re: Maureen Pickering dated March 28, 2014 and Service Ontario Confirmation Form	LTCI00065223 p. 7, 9
	• Caressant Care Residents Death Form dated March 28, 2014	LTCI00065223 p. 8
11.	• Telephone message from Dr. George dated September 22, 2016	LTCI00065227 p. 3
12.	• Letter from Dr. Mann to Helen Crombez at Caressant Care re: *Coroner's Authority to Seize* dated November 15, 2016	LTCI00064917
	• Letter from Dr. Mann to Nicole Ross at Meadow Park re: *Coroner's Authority to Seize* dated December 28, 2016	LTCI00065183 p. 9
13.	• Telephone Messages from Horvath family dated November 2, 3 and 4, 2016	LTCI00065189
	• Internal email messages re: Horvath family dated November 2 and 3, 2016	LTCI00065192
14.	• Internal email messages re: James Silcox materials in Coroner's archives dated October 27 and November 1, 2016	LTCI00065228
	• Internal email messages re: Records Retrieval Request for James Silcox dated November 1, 2016	LTCI00065229
	• Records Retrieval Request Form	LTCI00065230
15.	• Initial Report of the Medical Investigation into Eight Elderly People Who Died under the Care of Elizabeth Wettlaufer by	LTCI00065278 p. 3

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
	Dr. Michael Pollanen dated December 1, 2016	
	• Outlook meeting invitation re: Woodstock serial homicide cases – meeting with Crown and OPP re medical expertise dated November 3, 2016	LTCI00065299
16.	• Internal email messages re: OPP delivering medical records to Coroner dated November 4, 2016	LTCI00065300
	• Email from Dr. Pollanen to Det. Hagerman re: medical records dated November 6, 2016	LTCI00065301
	• Email from Dr. Pollanen to Det. Hagerman re: additional information dated November 6, 2016	LTCI00065298
	• Emails between Dr. Pollanen and Det. Hagerman re: medical records and additional information dated November 6 to 14, 2016	LTCI00065265
	• Emails between Dr. Pollanen and Det. Hagerman re: cremations dated November 11, 2016	LTCI00065292
17.	• Telephone message from Dr. George dated November 10, 2016	LTCI00065227 p. 4
18.	• Emails between Dr. Pollanen and Dr. Jeffrey Jentzen re: peer review dated November 9 and 11, 2016	LTCI00065264
19.	• PowerPoint presentation by Dr. Pollanen entitled “The Wettlaufer [sic] case: Preliminary review & meeting with Crown and OPP on November 16, 2016”	LTCI00065302
	• Email from Dr. Pollanen to Det. Hagerman re: PowerPoint presentation dated November 16, 2016	LTCI00065290
	• Email from Dr. Pollanen to Det. Hagerman re: further medical records dated November 16, 2016	LTCI00065289
20.	• Letter from Mr. Kelly to Dr. Pollanen re: opinion on disinterment dated November 17, 2016 (and covering email)	LTCI00065288 LTCI00065287
21.	• Letter from Dr. Pollanen to Mr. Kelly re: opinion on disinterment dated November 17, 2017 (and covering email)	LTCI00065283 LTCI00065282

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
22.	• Emails between Dr. Pollanen and Dr. Jentzen re: peer review dated November 28 and December 7, 2016	LTCI00065277
	• Email from Dr. Pollanen to Dr. Milroy re: peer review dated November 28, 2016	LTCI00065284
	• Emails between Dr. Pollanen and Dr. Auer re: peer review dated November 29, 2016	LTCI00065279 LTCI00065280
23.	• Emails between Mr. Kelly and Dr. Pollanen re: hypoglycemia dated December 2 and 3, 2016	LTCI00065263
24.	• Telephone message from Dr. Urbantke dated December 6, 2016	LTCI00065224 p. 9
25.	• Initial Report of the Medical Investigation into Eight Elderly People Who Died under the Care of Elizabeth Wettlaufer by Dr. Michael Pollanen dated December 1, 2016	LTCI00065278
	• Email from Dr. Pollanen's office to Mr. Kelly re: Dr. Pollanen's Initial Report dated December 8, 2016	LTCI00065276
26.	• Emails between Dr. Mann and Joanne Whitney (OPP) re: bodies coming to PFPU dated January 11 and 12, 2017	LTCI00065188
27.	• Case Information Sheet dated January 12, 2017 re: Arpad Horvath	LTCI00065254 p. 2-3
	• Case Information Sheet dated January 12, 2017 re: Helen Matheson	LTCI00065249 p. 21-22
28.	• Warrant for Post Mortem Examination re: Arpad Horvath	LTCI00065183 p. 22-25
	• Warrant to Take Possession of the Body of a Deceased Person re: Arpad Horvath	LTCI00065187
	• Warrant for Post Mortem Examination re: Helen Matheson	LTCI00065249 p. 17-20
	• Warrant to Take Possession of the Body of a Deceased Person re: Helen Matheson	LTCI00065212 p. 1
29.	• Emails between Dr. Pollanen and Mike Shkrum re: attendance at autopsies dated January 22, 2017	LTCI00065274

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
30.	• Report of Postmortem Examination dated January 26, 2017 re: Arpad Horvath	LTCI00065252 p. 27-32
	• Email from Dr. Pollanen to Dr. Mann re: Arpad Horvath autopsy dated January 26, 2017	LTCI00065186
	• Report of Postmortem Examination dated January 26, 2017 re: Helen Matheson	LTCI00065251
	• Neuropathology Consultation Request re: Helen Matheson	LTCI00065218 p. 2
	• Preliminary Autopsy Findings re: Helen Matheson	LTCI00065218 p. 30
	• Email from Dr. Pollanen to Dr. Mann re: Helen Matheson autopsy dated January 26, 2017	LTCI00065210
31.	• Emails between Mr. Kelly and Dr. Pollanen re: questions pertaining to autopsies dated January 27, 2017	LTCI00065273
32.	• Telephone call from Marie Elliot at Centre of Forensic Science re: toxicology testing of Arpad Horvath dated February 1, 2017	LTCI00065183 p. 26
	• Telephone call from Marie Elliot at Centre of Forensic Science re: toxicology testing of Helen Matheson dated February 1, 2017	LTCI00065207
33.	• Email from Mr. Kelly to Dr. Pollanen re: six new charges dated February 7, 2017	LTCI00065267
34.	• Draft report by Dr. Pollanen re: “R v Wetlauffer [sic] – the ‘living’ cases” dated February 8, 2017	LTCI00065269
35.	• Letter from Det. Sergeant Kevin Talsma to Dr. Pollanen re: medical records for six additional cases dated February 22, 2017	LTCI00065262 p. 27
36.	• Cardiovascular Examination Report by Dr. Cunningham re: Arpad Horvath dated February 28, 2017	LTCI00065252 p.21-25
	• Cardiovascular Examination Report by Dr. Cunningham re: Helen Matheson dated February 28, 2017	LTCI00065249 p. 10-13
37.	• Neuropathology Consultation Report by Dr. Ramsay re:	LTCI00065183 p. 10-15

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
	Arpad Horvath dated March 13, 2017	
	• Neuropathology Consultation Report by Dr. Ramsay re: Helen Matheson dated March 13, 2017	LTCI00065249 p. 14-16
	• Covering letter from Dr. Ramsay to Dr. Pollanen re: neuropathology report of Helen Matheson	LTCI00065218 p. 21
	• Email from Dr. Ramsay to Dr. Pollanen re: case A17-0128 and 0129 dated March 14, 2017	LTCI00065253
	• Evidence Collection Form re: Helen Matheson	LTCI00065218 p. 25
	• PFPU Exhibit Transfer Record re: Arpad Horvath	LTCI00065254 p. 8
38.	• Emails between Mr. Kelly and Dr. Pollanen re: status of postmortem examination reports etc dated May 3 to 20, 2017	LTCI00065259
	• Emails between Mr. Kelly and Dr. Pollanen re: contents of agreed statement of fact dated May 11, 2017	LTCI00065260
39.	• Peer Review Form by Dr. Milroy re: Arpad Horvath dated May 4, 2017	LTCI00065252 p. 11
	• Peer Review Form by Dr. Milroy re: Helen Matheson dated May 4, 2017	LTCI00065249 p. 9
40.	• Postmortem Examination Report by Dr. Pollanen re: Arpad Horvath dated May 8, 2017	LTCI00065252 p.1-10
	• Postmortem Examination Report by Dr. Pollanen re: Helen Matheson dated May 8, 2017	LTCI00065249 p. 1-8
41.	• Report by Dr. Pollanen entitled: “R v Elizabeth Wetlauffer [sic] (EW) – the ‘clinical’ cases” dated May 25, 2017	LTCI00065257
	• Enclosure to Dr. Pollanen’s report dated May 25, 2017	LTCI00065258
	• Email from Dr. Pollanen’s office to Mr. Kelly enclosing report dated May 25, 2017	LTCI00065256
42.	• Date of Coroner’s Investigation Statements (Form 3) re: Maurice Granat (status: preliminary) by Dr. Mann dated	LTCI00064916 p.9

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
	January 22, 2017	
	• Date of Coroner's Investigation Statements (Form 3) re: Gladys Millard (status: preliminary) by Dr. Mann dated January 22, 2017	LTCI00065221 p. 8
	• Date of Coroner's Investigation Statements (Form 3) re: Helen Young (status: preliminary) by Dr. Mann dated January 22, 2017	LTCI00065237 p. 8
	• Date of Coroner's Investigation Statements (Form 3) re: Mary Zurawinski (status: preliminary) by Dr. Mann dated January 22, 2017	LTCI00065248 p. 8
43.	• Date of Coroner's Investigation Form (Form 3) re: Arpad Horvath (status: preliminary) by Dr. Mann dated February 8, 2018	LTCI00065183 p. 8
	• Date of Coroner's Investigation Form (Form 3) re: Helen Matheson (status: preliminary) by Dr. Mann dated February 8, 2018	LTCI00065203 p.8
44.	• Coroner's Investigation Form (Form 3) re: Maurice Granat (status: final) by Dr. Huyer dated February 9, 2018	LTCI00064916 p. 1-3
45.	• Coroner's Investigation Form (Form 3) re: Arpad Horvath (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065183 page 1-3
46.	• Coroner's Investigation Form (Form 3) re: Helen Matheson (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065203 p. 1-3
47.	• Coroner's Investigation Form (Form 3) re: Gladys Millard (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065221 p.1-3
48.	• Coroner's Investigation Form (Form 3) re: Maureen Pickering (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065224 p.1-3
49.	• Coroner's Investigation Form (Form 3) re: James Silcox (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065227 p. 5-7
50.	• Coroner's Investigation Form (Form 3) re: Helen Young (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065237 p.1-3

EVENT/ TAB	SOURCE DOCUMENT	DOCUMENT NO.
51.	• Coroner's Investigation Form (Form 3) re: Mary Zurawinski (status: final) by Dr. Huyer dated February 9, 2018	LTCI00065248 p.1-3

TAB C:
RELEVANT LEGISLATION

Overview Report:
Office of the Chief Coroner and the Ontario Forensic Pathology Service

The *Coroners Act,* R.S.O. 1990, c.C.37 sets out the responsibilities of various entities, including long-term care homes, in reporting deaths.

The *Coroners Act* also mandates the role of local coroners and the OCC/OFPS.

TAB D:
RELEVANT OFFICE OF THE CHIEF CORONER AND THE ONTARIO FORENSIC PATHOLOGY SERVICE GUIDELINES, POLICIES AND PROCEDURES

Overview Report:
Office of the Chief Coroner and the Ontario Forensic Pathology Service

SUMMARY

Having regard to paragraph 2 of the Order in Council establishing the Commission, which requires the Commission to inquire into "the circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices, and accountability and oversight mechanisms," there are various OCC/OFPS documents relevant to the Commission's consideration.

Below, we have included such documents that are most relevant to the OCC/OFPS's role, at the relevant time, in handling the deaths of EW's victims.

We have also included selected Annual Reports from the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario (the "Committee"). The Committee conducts an independent review of the available records relevant to the specific cases referred to it and prepares an Annual Report with recommendations aimed towards the prevention of future deaths in similar circumstances.

Document	**Date (or Estimated Date Range)**	**Document No.**
Long-Term Care Home Deaths: When to Call the Coroner	Unknown	LTCI00069306
Memo A 603 from the Chief Coroner Dr. James G. Young to Ontario Coroners re: Palliative Care and Physician-Assisted Deaths	November 29, 1991	LTCI00071129
Memorandum #02-07 from then Chief Coroner Dr. Barry McLellan and then Consulting Forensic Pathologist Dr. David Chiasson re: Guidelines for Ordering External Autopsies/Examinations	July 12, 2002	LTCI00069324

Document	Date (or Estimated Date Range)	Document No.
Memorandum #03-09 from then Deputy Chief Coroner – Forensic Services Dr. Barry McLellan and President of the Ontario Coroners Association Dr. Albert Lauwers to All Ontario Corones re: Guidelines for Death Investigation **Enclosing:** Guidelines for Death Investigation First Edition – June 27, 2003	June 27, 2003	LTCI00071532 LTCI00071525
Memorandum #04-07 from Acting Chief Coroner Dr. Barry McLellan to All Coroners re: Coroners attending home deaths when attending physicians cannot or will not attend	March 12, 2004	LTCI00071110
Memorandum #04-04, Replacing Memoranda #A-557 from then Acting Chief Coroner Dr. Barry McLellan to Ontario Coroners re: Identifying and Reporting Cluster Deaths	March 14, 2004	LTCI00071365
Memorandum #04-05, Replacing Memoranda #629 and 629A from then Acting Chief Coroner Dr. Barry McLellan to Ontario Coroners, Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Public Hospitals re: Revision to the Institutional Patient Death Record Form	March 14, 2004	LTCI00071125
Memorandum #07-02, Replaces Memorandum #04-05 from Chief Coroner Dr. Barry McLellan to Ontario Coroners, Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Public Hospitals re: Institutional Patient Death Record (Version 3), Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner (includes Resident Death or Transfer Record) **Attaching**: Institutional Patient Death Record Version 3 and Procedure for Reporting Deaths of Residents to the Office of the Chief Coroner	February 16, 2007	LTCI00071113 LTCI00071112 LTCI00071111
Memorandum #07-03 from Chief Coroner Dr. Barry McLellan to All Coroners re: Quality Assurance of Coroners' Investigation Statements / Form 3	February 28, 2007	LTCI00071109 LTCI00071108 LTCI00071107

Document	Date (or Estimated Date Range)	Document No.
Attaching: Template of Narrative Elements Which Must be Included in All Coroner's Investigation Statements / Form 3, and Audit of Coroner's Investigation Statement . Form 3		
Memorandum #07-04 from then Chief Coroner Dr. Barry McLellan ~~to~~and Dr. Peter Cameron (President, Ontario Coroners Association) to All Ontario Coroners re: Guidelines for Death Investigation, addressing changes to the Guidelines for Death Investigation issued in 2003.	Apr. 12, 2007	LTCI00069332
Guidelines for Death Investigations, Office of the Chief Coroner, 2nd Edition	Apr. 12, 2007	LTCI00069330
Memorandum #07-07 from then Chief Coroner Dr. Bonita Porter and Raymond Prime (Director, Centre for Forensic Sciences) to All Coroners and Pathologists in the Province of Ontario, All Chiefs of Police, Director of Special Investigations Unit, re: Changes in Retention Schedule for Toxicology and Change in the Acceptance of Prescription Medication **Attaching:** Memorandums #00-01 (Jan. 24, 2000), #05-02 (Feb. 11, 2005) and #05-04 (Apr. 29, 2005) re: toxicology	Dec. 7, 2007	LTCI00069311 LTCI00069312 LTCI00069313 LTCI00069315 LTCI00069316
Memorandum #09-04 (replaces Memos #06-03 and #07-03) from Chief Coroner Dr. Andrew McCallum to All Coroners re: Procedures for Completing, Ensuring Quality Assurance, and Releasing Coroner's Investigation Statements / Form 3 **Attaching:** Narrative Template for Coroners and Audit of Coroner's Investigation Statement / Form 3	February 25, 2009	LTCI00071447 LTCI00071446 LTCI00071445
Memorandum #10-13 from Chief Coroner Dr. Andrew McCallum to All Coroners re: Investigating Coroners' Acceptance of Natural Deaths for Investigation **Attaching:** Best Practice Guideline #4 – Investigating Coroners' Acceptance of Natural Deaths for Investigation	September 20, 2010	LTCI00071449 LTCI00071435 LTCI00071436 LTCI00071437
Memorandum #11-07 from then Chief Coroner Dr. Andrew McCallum to All Coroners re: Correction of Best	June 10, 2011	LTCI00069318 LTCI00069319

Document	Date (or Estimated Date Range)	Document No.
Practice Guideline #7 re: Post Mortem Examinations (for apparent Accidents) **Attaching:** Memorandum #11-02 (Feb. 9, 2011); Best Practice Guideline #7; Memorandum #02-07 (July 12, 2002)		LTCI00069320 LTCI00069321 LTCI00069322 LTCI00069323 LTCI00069324
Memorandums from then Chief Coroner Dr. Andrew McCallum to: • "All Ontario Hospitals"; • "All Coroners" (Memorandum #11-11); and • "All Ontario Long-Term Care Home Licensees" (undated, and also from the Ministry of Health and Long-Term Care ("MHLTC"), advising that Hospitals are no longer required to routinely complete IPD Records for patients who attended the Hospital from a long-term care home and were not in the presence of the home's staff at the time of death. The second two letters also note that such deaths should still be listed in the long-term care home's Death Register, and the third letter reviews the new electronic IPD Record submission process and the new checkbox on MHLTC Critical Incident Reporting Forms to ensure IPD Records are submitted at the same time.	Dec. 7-8, 2011 (and undated)	LTCI00069326 LTCI00069331 LTCI00069333
Briefing Note of the Ministry of Health and Long-Term Care re: Inspecting Long Term Care Homes: Overview of the Long-Term Care Homes Quality Inspection Program	Aug. 8, 2012	LTCI00069308
Chapter 11: Institutional Deaths – Long-Term Care	June 2013	LTCI0069309
Business Case: Transformation – Reduction in Long-Term Care Facility Threshold Death Investigations	Unknown, est. 2013	LTCI00069303
Briefing Note re: Issue: Reduction of threshold death investigations in Long-Term Care Facilities	Sept. 12, 2013	LTCI00069305
Letters from Chief Coroner Dr. Dirk Huyer to: • Dr. Arlene King (Chief Medical Officer of Health); • Saad Rafi (Deputy Minister of Health and Long-Term	Sept. 13-16, 2013	LTCI00069294 LTCI00069329 LTCI00069292

Document	Date (or Estimated Date Range)	Document No.
Care); • Dr. Andrea L. Moser (Ontario Long-Term Care Physicians); • Linda Haslan-Stroud (Ontario Nurses Associations); • Rocco Gerace (College of Physicians and Surgeons); • Dr. Scott Wooder (Ontario Medical Association), notifying them that the OCC would no longer be routinely investigating and certifying "threshold deaths" (every 10th death) or deaths as a result of infectious disease outbreaks, in long-term care homes.		LTCI00069304 LTCI00069328 LTCI00069335
Memorandum #13-04A from Dr. Dirk Huyer to All Long-Term Care Homes and All Regional Supervising Coroners re: IPD Records	Sept. 16, 2013	LTCI00069325
Memorandum #13-04B from Dr. Dirk Huyer to All Coroners and All Regional Supervising Coroners re: IPD Records	Sept. 16, 2013	LTCI00069336
Death Investigations in Acute Care Institutions: Course for New Coroners	June 24-27, 2015	LTCI00069295

SELECTED ANNUAL REPORTS OF THE GERIATRIC AND LONG TERM CARE REVIEW COMMITTEE

Document	Date (or Estimated Date Range)	Document No.
Third Annual Report	Jan. 1993	LTCI00061304
Fifth Annual Report	Feb. 1995	LTCI00061306
Sixth Annual Report	Jan. 1996	LTCI00061307
Eight Annual Report	Feb. 1998	LTCI00061309
Eleventh Annual Report	June 2001	LTCI00061286

Document	Date (or Estimated Date Range)	Document No.
Twelfth Annual Report	Apr. 2002	LTCI00061287
Sixteenth Annual Report	June 2006	LTCI00061291
Seventeenth Annual Report	June 2007	LTCI00061292
Eighteenth Annual Report	Sept. 2008	LTCI00061293
Nineteenth Annual Report	Sept. 2009	LTCI00061294
Twentieth Annual Report	Sept. 2010	LTCI00061299
2010 Annual Report	Nov. 2011	LTCI00061300
2011 Annual Report	Nov. 2012	LTCI00061301
2012 Annual Report	Dec. 2013	LTCI00061302
2013-2014 Annual Report	Oct. 2015	LTCI00061296
2015 Annual Report	Oct. 2016	LTCI00061297
2016 Annual Report	Oct. 2017	LTCI00061298