FAX TRANSMITTAL

May 16, 2008

TO: Commissioner Stephen Goudge
And all Members with Standing in the
Pediatric Inquiry Into Forensic Pathology

FROM: Anne Marsden (Mrs.)
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RE: INVITED WRITTEN SUBMISSINONS

Please find attached my written submissions to the Goudge Inquiry for review of the Commissioner and all members with Standing.

As the submissions are only fourteen pages in length and with this cover fifteen pages I am submitting the submissions by fax rather than mail unless I hear from the Commission Counsel that you need an original copy by e-mail today.

I am unavailable for two weeks after 5:00 p.m. this evening.

Respectfully,

Anne Marsden

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SUBMISSIONS IN WRITING TO THE PEDIATRIC INQUIRY INTO FORENSIC PATHOLOGY AT THE INVITATION OF THE COMMISSION

1. While these submissions are late in comparison to other submissions they are only late because of the Commissioner denying an oral motion to allow presentation of the submissions orally and my attempts to address with the Lieutenant Governor of Ontario and the Attorney General the public inquiry not meeting the requirements of *The Public Inquiries Act.* Therefore, I submit the written submissions should be received and published the same as invited written submissions by other individuals who did not have standing:

DIRECT AND SUBSTANTIAL INTEREST NOT HEARD BY THE INQUIRY

2. My request to make an oral application for standing and to present a Motion to the Commission for the opportunity to make oral final submissions was refused. Such application would have set out the following direct and substantial interest in the inquiry: It should be borne in mind that I worked with a Review of Deaths Committee at McMaster for approximately 10 years and understood the concept of death reviews and the opportunity to prevent future deaths by an adequate and appropriate investigation process , that sought the truth and nothing else but the truth in terms of the cause of death. The truth could and probably is on occasion ***We simply do not know the cause of death.***

a) My family has suffered two pediatric deaths, one newborn and one a two year old in the 80's. Neither of the coroner's investigations were satisfactory to the family.

b) The newborn was according to witnesses, one of whom was a qualified nurse born healthy and reacting as a normal baby does. . The baby, while absent from the mother and family and in the care of hospital staff, was suddenly transferred to a Neonatal Unit in another hospital and was placed on life support. The baby's condition strongly suggested to the family that she had been dropped and discussions with the Head of the McMaster Neonatal Unit who I had a working relationship with, did nothing to oppose this strong suggestion. The family had the unpleasant task of pulling the plug on the baby after being told there would be little development beyond a vegetative state. It became obvious that addressing the matter legally to ensure accountability would be an arduous task the family were not up to physically, emotionally or financially and so as a member of the family who grieved the death of a baby I had my first taste of a family's grief tinged by anger that the truth of cause of death was not evident leaving other families susceptible to the same grief and anger..

c) The second baby death was stated to be SIDS. However, family did not believe the investigation was thorough enough and did not take all the facts into consideration to leave them confident that this was the truth for the cause of death and to this day they wonder if a proper investigation might well have changed the cause of death from SIDS..

d) In the 90's and from 2006 on I played a significant role in family communications regarding three Burlington community deaths involving a teenager, a young adult and an 86 year old lady with coroners associated with the OCCO..

e) The death of the young adult was connected to an Indoor Bike Track where the evidence was supplied to the coroner and police (in relation to reporting duties under *The Corners Act)* that the track was allowed to open regardless of community concerns of those familiar with such tracks that the concrete pillars located next to the track were dangerous and created a "death-trap" environment. Damian Headley died after his helmet clad head struck one of these pillars. Despite an inquest and the involvement of a highly respected OPP investigator neither the family nor many in the community were satisfied with the outcome of the death investigation and were concerned, until recently that the same conditions existed on an outside track in Burlington that could see a repeat of this tragedy.

f) The death of the teen was connected to Halton Regional Police actions where the SIU failed to get involved after, according to Dr. Jim Cairns, being given the facts of this matter. I was the family representative who communicated with Dr. Cairns who headed the investigation. After numerous attempts to obtain an inquest to address the various issues connected with the death that police claimed was a suicide but this investigator believed there was evidence to suggest otherwise the family who were also dealing with two parents who suffered from deafness, keeled under the emotional and financial stress and closed down their attempts to obtain the truth through inquest. They publicly stated,

however, as they announced their withdrawal from the investigation and request for inquest their son's death was related to injustice.

g) The third death was that of my 86 year old mother. My mother's body was transferred to the forensic laboratory by Dr. Porter because of the concerns raised previous to death that this should be treated as a suspicious death. The family fulfilled their reporting responsibilities under the *Coroners Act* but have been let down when seeking the truth about the cause of death by the death investigation team which has included five coroners, two of whom were Regional Supervising Coroners and one of whom was Deputy Chief Coroner of Ontario. The evidence in the chart shows the deceased was given more than six times the approved treatment for the CHF she was diagnosed with by the Joseph Brant ER on April 3, 2006. Her medical history showed previous overdose lead to aggressive treatment for dehydration and renal failure. The chart t also shows she suffered 10 bouts of severe diarrhea that went untested as to cause and untreated and that she died within 24 hours of the onset of these symptoms during what the hospital deemed to be a Norwalk Virus crisis. The first Coroner to review the chart and thus understand the circumstances she died in was also the Chief of Staff at the hospital. Having supported three Chiefs of Staff fulfil their responsibilities to the Board of Governors and the community I thoroughly understand the responsibilities of this Chief of Staff to test the cause of the diarrhea to determine if it was 1. part of the Norwarlk Virus crisis 2. from medications given without consent 3. related to a superbug that was also in the hospital. Dr. Michael Gardam's report on c-dificile at this hospital which was related to 62 deaths at the hospital (diarrhea is a symptom) has confirmed that

his review started less than a month after the death of my mother, May 2006, at the hospital where he conducted his review, based on a spike in c-dificile cases in May, 2006. Dr. Gardams opinion has been sought but not received as to whether testing for diarrhea during what is deemed to be a Norwalk Virus Crisis is an appropriate and expected procedure to help abate infection control crises such as the c-dificile outbreak at Joseph Brant Memorial Hospital. .

h)) My working relationship with the OCCO, OPP, families and the Chief Coroner of Ontario and Deputy Chief Coroner of Ontario and the utilization of my nationally respected audit skills led me to the conclusion that the five coroner cases that personally affected me and my community were inadequate to say the least and impacted on community safety as a result of inadequate investigation. Further there was evidence to support a criminal investigation into false return of a coroner under Section 128 of the Criminal Code and this was addressed to several Ministers and OPP Commissioner Julian Fantino who have not as yet responded as to jurisdiction of such an investigation.

2. These submissions concentrate on the death investigation team given the Commission has heard evidence about the role of the coroner as leader of the death investigation team and the position of The Affected Families Group that the senior management in the OCCO did little to stop the injustices that came about as a result of Dr. Smith and what he calls errors and mistakes.

3. In the 70's and 80's I worked with a hospital Review of Deaths Committee for around ten years and was very much involved in the credentialling and disciplining of medical staff who breached the standards expected of them. I worked closely with the Chief of Staff, CEO of the Hospital and with Heads of Section and Chairmen of Departments on the very issues discussed by this inquiry in terms of oversight and dealing with medical and university staff, respected at the international level who were not cutting it in terms of their responsibilities to their patients, the hospital and the community. Since the 90s and to this very day I have been advocating in the community with regard to access to healthcare, justice and facilities utilizing my professional skills and the experience I gained working with internationally respected role models at least one of whom sat on the Review of Deaths Committee I worked with. . Since March 5, 2008 age and disability, however, have led to my limiting my efforts to those situations associated with my own family experiences.

4. In 2006 my auditor and rights advocacy pro bono role lead to a presentation at the International Conference for the International Center for the Study of Psychiatry and Psychology which was well received and included in the conference video. The success and encouragement I received both from the professionals who organized the Conference to those who heard my presentation led me to take bigger steps forward in my auditor and rights of access to justice, health care and the community advocacy role.

5. My professional and vulunteeer experiences have allowed me to audit the OCCO and I believe those audits present a perspective to the Inquiry that no other person or group

with standing has yet brought forward. The audits, I submit, show there has been no change in the OCCO despite the awareness of the public and our government that all is not right with death investigations in Ontario beginning with the Public Inquiry set in place after the investigation of the death of Tammy Homolko noted as the Campbell Inquiry.

6.. January 8, 2008 the Commission heard from Dr. Alberta Lauwers with respect to ensuring the pathologist gets the necessary information from a coroner prior to the commencement of the autopsy. . Dr. Alberta Lauwers used the case of a 35 year old who died in the community (in hospital) to illustrate the contribution a clinical physician who is a coroner can impart on the system. The acceptance by the Commissoner of this approach gives credibility to my use of all my experience with five unsatisfactory death investigations where the deceased ranged in age from newborn to 86 years old as my contribution to this inquiry whose mandate is to restore public confidence in pediatric forensic pathology.

7. The purpose of my submissions is to bring to the attention of the Commissioner the concerns obtained from audit of the death investigation processes that I have been involved in that does not support the position of the OCCO *that the OCCO through its dedicated leaders has continually strived to enhance death investigations in the province in an effort to promote public safety and prevent future deaths*.....

Part II – Limitations of the Death Investigation System 185 OCCO Final Submissions

on the contrary the evidence from my experience and audit is more in line with that of the Affected Families Group position in their final submissions which generated a response from the OCCO:

As set out in Parts I and II of the Final Submissions, those in senior management at the OCCO during the 1990s and early 200s neither ignored nor minimized concerns about Dr. Smith that were brought to their attention.

8. After auditing three death investigations one of which has been in place since April 9, 2006 and is still far from complete in the eyes of the family my position, supported by evidence, is:

Senior management within the OCCO and succeeding Ministers responsible for the OCCO ignore and minimize concerns emanating from the death investigation team including concerns related to a false return to the process.

9. The example and evidence I have to support this position relates to the death investigation of Mrs. Eva Bourgoin, my mother and the events that occurred April 3, 2006 to April 9, 2006.

10. April 3, 2006 Mrs. Bourgoin was sent by a very concerned and caring doctor who knew Mrs. Bourgoin's medical history to the ER at Joseph Brant for an x-ray and bloodwork to determine if Mrs. Bourgoin had CHF. The doctor knew how hard the approved treatment for the CHF was on Mrs. Bourgoin's kidneys and would not start the approved and effective treatment programme unless x-ray confirmed his suspicions. Given Mrs. Bourgoin had been successfully treated for CHF in her home, Brantwood Lifecare Centre in Burlington on several occasions and the hospital was known to be a

dangerous environment for her it was expected by all involved that immediately after the x-ray was taken she would be sent home by ambulance – but this did not occur instead she was admitted .

11. Audit of the medical chart showed:

- no medical history was taken although legislated as required for such admission
- the decased received more than six times the approved amount of the proven safe and effective treatment for CHF (a total of 380 mg. instead of one only 60 mg. dose)
- the ER staff had requested and received by fax a copy of the Administration Record from Brantwood Lifecare Centre that showed one only 60 mg. dose of lasix was the approved and standard treatment for CHF diagnosed by x-ray for the deceased. .
- the deceased suffered ten bouts of severe diarrhea which besides being properly recorded in the chart was also referred to in the progress notes "incontinent of huge amounts of base stool x 2 this shift" and "remains with diarrhea" both recorded with dates of April 9, 2006 the date of death with death occurring at 9:00 p.m.
- deceased was discharged April 6, 2006 but did not leave the hospital.
- the no CPR request if the patient was found with no vital signs discussed in the ER with nursing staff on the evening of April 3, 2006 was not documented in the chart and as a result CPR was instituted after deceased was found with no vital signs and could have had no vital signs for a 25 minute period.

12. Audit of the warrant provided to the forensic laboratory with the body shows:

- no mention of Norwalk Virus being a crisis in the hospital
- no mention of lasix overdose or history of renal failure and dehydration associated with lasix.
- no mention of 10 bouts of severe diarrhea

13. Audit of the death investigation process shows:

- autopsy report completed by Dr. Pollanen July, 2006 was withheld from the family until November, 2006 who received it after the report was released to an outside agency and the family determined it was available.
- the results of vitraous humour tests conducted by Dr. Pollanen as a result of information in the warrant and the chart were not provided to the family with the report and not until they determined their existence in the meeting of February 20, 2007 and repeatedly requested a copy.
- Dr. Pollanen advised through autopsy report and Regional Supervising Coroner that kidney failure occurred prior to death and autopsy did not rule out contribution of dehydration to death. (kidney failure and dehydration were previous consequence of lasix overdose that determined 60 mg. as safe and effective dosage) but not one of the coroners involved refer to either on their form 3 (Investigation of the death form) as submitted to the family by Dr. Porter. .

- evidence presented to Regional Supervising Coroner and OPP on February 20, 2007 that symptoms of lasix overdoes were noted by family on April 5, 2006 and a request was made for confirmation that no more than the 60 mg. was being administered which was the only dose of lasix that had consent.
- blood pressure upon receival at the ER was 220/180 despite hypertension medication administration for weeks prior to arrival at ER. Blood pressure returned to normal at 5:00 p.m. after medication effect peaked. No more of this medication was administered and blood pressure remained stable until death..
- Regional Supervising Coroner responded to question as to why known fractures were not referred to in the autopsy report as being because no x-rays were taken because this was a natural death investigation.
- The last investigating coroner whose report is on file claims there was no overdose of lasix and follows the pattern of the previous coroners which ignored the evidence of death associated with overdose with lasix and severe diarrhea. and the position of the pathologist that renal failure occurred and autopsy did not rule out dehydration contributing to the death.

THE ORIGIN OF THINK DIRTY

Justice Campbell found that the investigating Coroner, Dr. Joseph Rosloski *`faced with a puzzling and unexplained death, felt it his duty to come up with some kind of tidy answer and fell back on asthma as a cause of death without thinking it through as clearly as he might have and indeed without knowing how she died.``*

Campbell went on to conclude that:

`It was inappropriate for Dr. Rosloski to submit a final report showing death by natural causes when there was a dramatic and unexplained second degree burn over much of Tammy`s face, inappropriate to report that she died by means of natural causes when he did not know how she died, and inappropriate to list asthma as a cause of death when he had no evidence tht asthma caused or contributed in any way to her death.``

And, after hearing that after the arrest of Bernado – Tammy Homolko`s brother-in-law for ``the Scarborough rapes`` the Coroner`s investigation into Tammy`s death was reopened by Dr. Young and Deputy Chief Coroner, Dr. Jim Cairns.

Justice Campbell notes in a section of his report called The Coroners system that *a number of changes have been made by the Chief Coroners Office in the system of death investigation as it existed at the time of Tammy Homolkas death.*

The first change that he set out in a list of eight changes is *Training and reinforcement in the need for coroners to* ***think dirty in the face of suspicious circumstances.***

Justice Campbell also zeroed in on the fact that a rape kit had not been administered in the post-mortem examination of Tammy Homolka although the possibility of sexual activity was briefly considered.

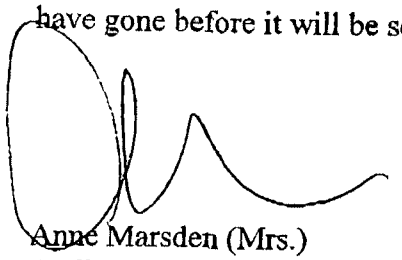
DR. POLLANENS POSITION ON WHAT THINK DIRTY MEANS

Dr. Pollanen was very clear in response to questions from the Commissioner that **think dirty** is simply to think truth..... *if you are allowing the facts to guide your thinking they will guide you in the correct direction.* - Excerpt from transcript evidence of Dr. Pollanen.

CONSEQUENCE OF LACK OF PUBLIC CONFIDENCE IN DEATH INVESTIGATON PROCESS

I submit that restoring the public confidence in pediatric forensic pathology is an impossibility if public confidence is not restored in the death investigation process. The Campbell Inquiry sought to show that changes were made in the death investigation process after the Tammy Homolka experience but audit related to three deaths that affected community safety shows public cannot have the confidence that this is the case. My five death investigation experiences for the full range of ages from newborn to 86 years of age have left me with the perception that 100% of the death investigations I have been involved with were not of the quality where family and community could feel confident that the mandate of the OCCO was fulfilled. One out of five would be reason enough for myself and the families who live in the communities where the deaths occurred to question whether we should be trusting the OCCO to fulfill its mandate given the Tammy Homolka experience and commitments made after the Campbell Inquiry. . Five out of five I submit means drastic measures have be taken by those involved in

oversight of the OCCO and those drastic measures need to be reflected in the recommendations that come out of this Inquiry or the Goudge Inquiry like the ones that have gone before it will be seen by those who are affected as simply a smoke screen.



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