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PRESS RELEASE

AUTOPSY OF AN AUTOPSY OF AN ONTARIO SCHIZOPHRENIC

Today is the start of the Goudge Inquiry, funded by the people of Ontario that will try and figure out why Charles Smith repeatedly screwed up on his opinions generated from pediatric autopsies he conducted. Anne Marsden advocate and auditor with Access for All was denied standing at the Inquiry and the opportunity to present her application publicly. Today the results of an audit by Mrs. Marsden of an autopsy and death investigation that involved four coroners and the Chief Pathologist of Ontario, have been mailed to the College of Physicians and Surgeons in the form of a well evidenced complaint that the four coroners and pathologist involved in the death investigation of 86 year old Eva Bourgoin at Joseph Brant Memorial Hospital who died April 9, 2006 operated outside their professional standards and such constitutes professional misconduct. Audit shows the important facts associated with the death were:

No medical history obtained for the patient (**labelled as a schizophrenic)** who went to the hospital for diagnosis and treatment of CHF and was admitted April 3, 2006 …… She was overdosed with lasix (a diuretic with dehydration changed renal function as side effects) without consent contrary to the effective established treatment set out in the medication administration record provided to the ER and attending physician……She was discharged back to long term care on April 6, 2006 with excellent vital signs and pre-admission health status ….. The hospital administration failed to effect the discharge despite instructions from the powers of attorney they had to do so and knowing the hospital was a dangerous environment for Mrs. Bourgoin……There was a Norwalk Virus outbreak in the hospital and on the ward the day she died…… She had 10 bouts of diarrhea called Norwalk Virus symptoms by nursing staff April 8, 2006 and April 9, 2006. The attending physician did not order tests to establish the cause of the diarrhea, and did not treat the diarrhea ....Despite powers of attorney instructions that there should not be any attempts at resuscitation a team lead by the head of the ER tried to resuscitate her after she was found dead 25 minutes after anyone had seen her alive.

The evidence submitted to the College is that the normal protocol for a forensic autopsy was not followed by the Chief Pathologist of Ontario. Vital information concerning lasix overdose and 10 severe bouts of diarrhea, lack of testing or treatment and the Norwalk Virus outbreak were missed by the initial coroner when he made out the warrant that accompanied the body. Two Regional Supervising Coroners got involved in the matter contrary to the Coroners Act and denied access to the autopsy report and tests which established dehydration contributed to the death for four months and eight months respectively. The Chief Coroner was involved immediately it was determined the warrant missed out relevant information. Monte Kwinter refused an investigation of the Chief Coroner`s actions associated with this matter claiming it is now being investigated by Dr. Cairns, Deputy Chief Coroner. **Further information from Access for All**