ST. MURDER HOSPITAL!

Michael Sklar – <u>MURDERER!</u>

Seema Marwaha – <u>MURDERER!</u>

Police Report Number: 24-1621628

DOCTOR MICHAEL SKLAR OF TORONTO'S ST. MICHAEL HOSPITAL — OR, MORE APPROPRIATELY, ST. MURDER HOSPITAL! — murdered my Mother just as surely as if he had put a bullet through her brain! Because she was one-hundred-years-old, SKLAR *feloniously* changed my order, my Mother's order — and the order of the Emergency Department (ED) Dr.'s order from "FULL CODE RESUSCITATION AT ALL COSTS!" to "DO NOT RESUSCITATE (DNR)." With one stroke of his pen he sealed her Fate — and his own! And then he and his so-called "medical team," including Dr. Seema Marwaha, simply stood by and watched her die in agony! He pulled the trigger — but *she* loaded the gun. (I witnessed it all!)

JOSEPHINE VICTORIA LONSDALE (HEUGHAN) was a WWII decorated, front-line veteran nurse…. But now it took all of my strength just to hold up her head with my left arm and try to pump life back into her lungs with my right — all the while begging and pleading with them to "Help! Please! — *Do something!* — Help her! — Please! For God's sake! — Please!!"...

Nothing…. They just stood there, casually looking on as though they were studying an ant hill colony…. My mother died in my arms, as I held her sweet face in my two hands and rolled her lifeless head back and forth and kissed her face over and over in a vain attempt to restore her to life! — "Mom! Mom! — Come back! — Please! — Come back! — I love you so much! — Please! Please! Mom! — Don't leave me!" …But it was too late… she was gone.

I looked up at that Murderous Group, and as I held my Mother and gently rocked her back and forth, I swore to them on her dying breath that "Destiny has now reached out and touched *each and every one of you* who willingly participated in the premeditated murder of my Mother — and the indignity to her body by that big, black male C.A. (Clinical Assistant) after death!" IN THAT *MURDEROUS PLACE* …before a ***TIME-AND-A-HALF*** and a ***MONTH-AND-A-HALF*** have passed, then shall *their* pangs of agony begin!…. The writing is *now* on the wall: "Mene, Mene, Tekel, Upharsin" (Daniel 5:25). The Scales *Must* Be Balanced! "La Forza del Destino." (The Force of Destiny.)... Malocchio. (The Evil Eye!)

— <u>SO</u> <u>HELP</u> <u>ME</u> <u>GOD</u>!!!!

ST. MURDER HOSPITAL!

…My beloved Mother's Soul *reluctantly* departed this life on Sunday morning, July 23rd, 2023, 2:20 a.m., aged 100 years — no thanks to the so-called "medical team" at Toronto's infamous *ST. MURDER HOSPITAL!!!*, also known as St. Michael's. Ha! — There's a laugh for you!

Even at a hundred my Mother was still in good shape, thanks to my ever vigilant nursing skills, which included exercising her daily with a couch pedal-bike and a 5 lb. dumbbell, respectively, so that she could walk down the front, four veranda steps onto the street (with me holding her two hands out in front, as you would a child just learning how to walk) and then get in my car; the dumbbell was to keep her biceps strong enough to feed herself. Every morning I would clip a paper towel onto her shirt collar to protect her clothes from the spilling food, as she relished still being able to feed herself. She looked so cute sitting there in her little robin-egg blue t-shirt and pedal-pusher pants, white hair and bright blue eyes, that she reminded me of a two-year-old who was just learning how to eat.

A decorated WWII veteran: Canadian Women's Army Corps (CWAC), she served her country well as an army nurse. Her mother, Hazel, aged 26, died from drudge labor, working for the wealthy, when Mom — along with her siblings — was only about five years old. She survived The Great Depression of the "Dirty 30's", ran with "the mob," became a circus high-platform diver with Conklin Shows (diving from 110 ft. tiny platform into a tub of water only 8 ft. deep!), was a Red Cross ambulance driving nurse during the London Blitz — picking up the wounded and dying — and rushing them to the nearest First Aid stations! In peacetime, she worked as a nurse at Sunnybrook Hospital. I make mention of all this to indicate what a tough little woman she truly was — and also as a preamble to the concatenation of tragic events at St. Murder Hospital, which I am about to relate:

…It began that weekend, early Friday evening, July 21st, 2023 following her daily routine of ablutions (which I always performed for her) — and after her pedal-bike-and-dumb-bell exercises. I turned on the TV news and we watched the *flash*-bulletin about the death of 96-year-old vocal crooner Tony Bennett. Suddenly my Mother began regurgitating her lunch! At first I thought nothing of it and just changed her bib; but then as night progressed she was throwing up about every fifteen minutes, or so. She did occasionally vomit over the last few months, but I chalked it up to maybe some food I had left out too long, or perhaps her bad posture on the sofa, while she ate. But this — this was alarming! I gently held her hands in mine, wiped her mouth and continued to change her bib. I could see the growing fear in her eyes and she saw the worried look in mine, as she began clasping both my wrists. Finally, I said: "Mom, I'm gonna call an ambulance."

When the paramedics arrived, they took her vitals, which they said were pretty good. But after we reached St. Murder Hospital — we had to wait at least seven hours in the hall until finally they came and took her blood and a stomach x-ray; and then we waited… and waited… then waited some more….

All through that night my mother was getting worse — and still trying to throw-up, but of course there was nothing left to throw-up, except bile. Not to mention the diarrhea — which by now was just water — and yet we were still in one of the Emergency Room (ER) cubicles (A2) waiting for tests. The attending doctors: "Dr. Dave" (from Ireland), Dr. Jennifer Chu, Dr. Cole Clifford (Sr. Resident) — and the "medical team" led by Dr. Michael Sklar and Dr. Seema Marwaha, finally appeared. Dr. Dave looked to be about 15-years-old and should have been sucking on a lollipop. — Then suddenly my Mother wretched up a blob of dark, dried, brown-y old blood that at first we thought might be fecal matter! Such things do occur, albeit rarely. But it did seem to be very old blood that may have been in there for quite some time. And yet, even with a roomful of supposedly well-experienced emergency medical staff — they were *all* in shock! Flummoxed! Didn't seem to know what to do! — I grabbed a nearby towel and wiped her mouth, "sniffed" it…. No discernible odor. I should add that my Mother was still alert and sitting up against the bed, which was cranked to about 45 degrees. Then some test results came back and the guessing games began:

They held up the x-ray to the light: "…Well, her abdomen is severely distended, but maybe it's just full of air?" declared Dr. Marwaha. ("You mean, full of air, like you — you moron?") And then she added: "Her creatinine levels are too high!"

"Well they weren't when we first brought her in here — over seven hours ago! Why didn't you begin treatment then?!"

Dr. Seema Marwaha proffered another guess: "...It could be a twisted bowel, but there definitely seems to be some kind of a *small* blockage."

'Definitely?' 'Seems to be?' — "Which is it? You've got the x-ray right there in your hands — can'tcha see what's causing the blockage?"

"Well, we really can't tell much from an x-ray — we'll have to do a CAT scan."

"Well, why in the hell didn't you do that hours ago — when she was still a lot stronger?!"

This was followed up with the usual excuses for their complete incompetence: — "blah-blah-blah, yada-yada" — apropos nothing. My Mother hadn't eaten anything all that Friday night and now we were into the early Saturday morning hours. She was already in a state

of semi-consciousness as they ran a tube up through her nose and down into her stomach to drain off the dried matter of “coffee grounds", as they called it…. More waiting for test results…. Suddenly a “speech therapist” showed up, with a cheese sandwich and apple sauce and tried to force them into her mouth!

“Are you entirely nuts?!” — I screamed. “What’n the hell do ya’ think you’re doing?! — Can’t you see she’s barely conscious? Just because her bed’s cranked up, you think she’s alright?! Your I.Q. must come in at room temperature — and I mean celsius, not fahrenheit!...” She sheepishly tip-toed from the room and disappeared.

So the inserted plastic tube, now in her stomach, started bringing up the putrefaction. They decided to move her up to the wards from the ED. She was barely conscious! They should have kept her in the ICU (Intensive Care Unit). I asked one of the nurses, making up her bed: “Why is she up here in the wards and not in the ICU? She’s very weak after waiting all these hours without any nourishment. She needs to be in chronic care.” Her reply simply was — “Oh, I don’t know, you should have asked the head nurse down in ED.” After that rejoinder, I realized my Mother was in *real* trouble! — plus, we were on the 13th floor, even though they call it the 14th; so the elevator goes from the 12th to the 14th, *no* 13th floor in between. My Mother was in room 60, directly across the hall from the doctors’ and nurses’ administration desk. I asked the attending doctors when they were going to do the CAT scan?

Answer: the de facto or de jure leader of the surgical team, Dr. Michael Sklar, an anesthetist, who looks more like Edgar Bergen’s Mortimer Snerd, now decides to broadcast from the foot of my Mother’s bed: “WELL, YOUR MOTHER'S DYING! SHE’S FAR TOO WEAK TO BE MOVED ONTO A STRETCHER AND TAKEN DOWNSTAIRS FOR A CAT SCAN!” — And he’s smiling all the while he’s telling me this! (The tone of his voice reeked of schadenfreude.)

“Do you think you could possibly announce that ‘SHE’S DYING’ just a little bit louder?” I responded. “I don’t think they can quite hear you over at the corners of Queen and Yonge Streets! For God’s sake — she’s right here — in front of you!”

His grinning front teeth were so far apart, like *Mortimer Snerd’s teeth — (1930s and ‘40s ventriloquist Edgar Bergen’s two knee-dummies who were respectively named: Charlie McCarthy and Mortimer Snerd) — that I would have bet he could eat a cob of corn sideways through a picket fence! Again I asked: “What about the blockage?” His reply: “Regardless of *whatever* is causing the blockage, it really doesn’t matter anymore, because now she’s in the *transitional stage*.”

“Transitional what? What the hell’s that? — A euphemism for dying? Do the surgery! I have her power of Attorney — Do it now! — and the CAT scan! — while there’s still a chance! — You

just said she's dying — with or without it — so what's there to lose?! She wasn't too weak when we first got here — eight hours ago! You waited too long!! — Why didn't you do the Goddamn CAT scan and the surgery then?! — WHY??!"... Then more "blah-blah, yada-yada" — more bullshit excuses. During our seven hour wait in the Emergency hallway Sklar barely glanced at her — even though he walked past us dozens of times!

…By now, it was late Saturday night, and I was exhausted. I whispered in my Mother's ear that I had to try to sleep a while. But as I sat in that chair and put up my stocking feet beside hers, she was still trying to tell me — even with that tube in her nose — that she was hungry! After all, she hadn't eaten a thing in nearly two days! I dozed off for a while. But when I woke, there was that goofy-looking Sklar again — aka Mortimer Snerd, buck teeth and all — just standing there and staring me right in the face and shouting: — "YEAH, WELL, YOUR MOTHER'S DEFINITELY DYING!"

"Jesus Christ! — Can't you keep your voice down?!"

He says: "Well, she needs to know what's going on, too."

"No, she doesn't! What's the good if you're not going to help her?! And by the way, where in the hell did you get *your* medical degree — at the Helen Keller School of Medicine?"

Then, he leans over to where I'm sitting beside my Mother, and says: "AH-H-H — YOU'RE UPSET — HERE, LET ME GIVE YOU A BIG HUG!"

"What the — ?! …Get the fuck away from me!" (Incidentally, this "Dr." Sklar is *only* an anesthetist, not even a surgeon; he puts people to sleep — some probably permanently!) "By whose authority did you have to reverse my Mother's 'Resuscitate at all cost!' (full code) to 'Do not resuscitate (DNR), palliative care, only?' "

"Ya' know, Doc, over the last ten years my Mother has been written off in this alleged hospital as *dead* or *dying* by other similar morons, and each time she's pulled through — mainly because I didn't listen to them try to talk me into a DNR designation.

"Every one of them tried to talk me into invoking the *'Do not resuscitate'* code and each time I refused! Whadda' you guys do — get paid piecework for every elderly patient you knock off?

"What is it? — When someone reaches 90 or 100 years you figure: — 'Ah, what the hell — just let her die?!' Whatever happened to your hippocratic oath? '...First, do no harm!' Sounds to me like you and your so-called medical team are no better than MURDEROUS HYPOCRITES — with a license to kill! If it weren't for people like my Mother, putting their lives on the front-lines

during WW II — you and your idiot colleagues wouldn't be enjoying the luxury of the fat, spoiled, selfish, self-indulgent life-styles that you now do — including killing the very people — the War Veterans — who saved our Democracy!"

By now it was getting onto midnight — and beyond — and my Mother's breathing was becoming more rapid and shallow, made none easier by that plastic tube in her nose. I kept yelling at the nurses — "Get the antibiotics into her — now! — Levofloxacin — it always works!"

"Sorry, sir, but the doctors have not prescribed it."

Mom began weakly calling to me again, but she was difficult to understand because of that tube. "...Tony, Tony… I, hungry… thirsty…." I had always figured, and usually correctly so, that if she could still eat — or at least felt hungry — she would recover. But this time she hadn't had anything to eat in nearly two days, except for that sugar and water IV, because of the vomiting, which by now had subsided. (I'll regret until my dying day that I didn't give her a couple of Levofloxacin antibiotic tablets, as I usually did, before the ambulance brought us to this abattoir. Those pills always seemed to pull her through — even with COVID!!)

I dipped my two right fingers into a paper cup of water to wet her lips and mouth, she was so dry and thirsty. This was exactly midnight: the wall clock said, 00:00. Two hours later, by 2:00 a.m. Sunday morning, her breathing became more rapid — yet I still held her in both my arms, hugging and kissing her and telling her how much I loved her. Out of pure panic and desperation, I gently laid her head back down on the pillow — then darted across the hallway to that doctors' and nurses' administration office, where the lollipop kid, Dr. Dave, was sitting at his computer while some young nurse-administrator was chatting him up. I yelled — "Doctor Dave — come quickly! My Mother, she's not breathing right!" — Suddenly startled by my appearance and urgent call for help — he half-jumped up from his chair, and stuttered — "Oh-h, ah-h, ah-h-h — I'll be right there, in just a minute… I need to fix something on my computer."

" — NO! NOW! — RIGHT NOW!!" — and I grabbed him by the scruff of the neck and one arm and hauled him towards the door! — "Quick! — She's dying!!" Then that same young nurse-administrator — without even turning around in her chair to see who it was that was in such a panic — blurts out — while still looking at Dr. Dave — "Get out! You're not supposed to be in here!"

"What the fuck did you just say to me! — you heartless, selfish bitch! — I'll deal with you later!! I ran back across the hall — with Dr. Dave in tow — where the duty nurse, Donna, was taking her own sweet time wrapping the BP (blood pressure) cup around my Mother's arm, checking for vital signs…. waiting…. — Well, what the fuck're ya' waitin' for?!!"

I wrapped both my arms around her again — and kept crying out — "Mom! Mom! — I love you! — I love you so much! — Please! — Please don't leave me!!" I knew she heard and understood me because at that very moment she opened her bright blue eyes — looked straight at me and quietly said: "...I know." Which is exactly *why* I used to tell her every night at home for the last eleven years *that I loved her*, after I put her to bed and turned off the lamp: "Good night, Ma, I love you"; then there'd be a brief pause… after which she'd reply: "I know. Me, too." …I began telling her I loved her each night starting eleven years ago because ST. MURDER HOSPITAL had nearly killed her — even back then! It was April 3rd, 2012, when the so-called triage nurse misdiagnosed the "fatal" heart attack she was having *right in front of her at that exact moment!* Had it not been for the quick action of a brilliant young cardiologist from Saskatchewan, Dr. Michael Kutryk, she would have died that very night, 11 years ago, as we sat in the *small* Emergency Room for hours — fighting off druggies and drunks who were trying to steal our drinks, while my Mother slowly developed cyanosis. (Turning blue from lack of oxygen!)

Again I yelled to the attending nurse, who kept saying — "I have to wait until the machine warms up. Besides," she added, "We don't do resuscitations up here."

"What?!! — You mean you're directly countermanding an order from the ED doctor to 'resuscitate at all costs'?" "Well," she said, "Dr. Sklar changed it to DNR." Then that mouthy bitch of a nurse-administrator from across the hall casually strolled in and mouthed that tired platitude, "I'm sorry for your loss."

"What?!! — You fucking bitch of a hypocrite! Not as sorry as you're gonna be! You walk in here — now — just as my Mother took her last breath?! I swear to you, right here and now, as her Soul departs this world, that you will never know a moment's happiness from this point on — not for the remainder of your short, miserable life! And if there's *anything* I can do to exacerbate that process, you can bet *your* "*life*" I will! And as time passes, and everything keeps getting worse for you, and you think you just can't take any more because it couldn't possibly get any worse — IT WILL! — GET WORSE!!! — *AND WORSE*!!!!

"…You don't believe me? Go and ask some of the long-time staff here who knew my Mother — and my decades-long history of *accurate* World Predictions that continue to be published around the globe through *FLASH NEWS* wire service (25,000 media outlets — worldwide!), and other general media."

…I sat beside my poor Mother far into the night and early hours of Sunday morning, hugging and rocking her back and forth, unable to grasp the reality that she was gone. But I was grateful for one thing, that before she slipped away she was conscious long enough to hear me tell her

over and over: “Mom! — I love you! — I love you so much!! I shoulda’ done more! — I shoulda’ stayed home with you more — especially every time you said you were feeling lonely. Instead, what was I doing? Going out and playing my sax in some dirty, divy little bar for a few measly bucks. Big deal! And for what? I coulda’ — shoulda’ — spent all that lost precious time with you — *you* who *truly* deserved *all* my time. And now, it’s too late… too late.”

My Mother died at precisely 2:23 a.m., July 23, Sunday morning, 2023. Because I, alone, looked at the clock on the wall above the foot of my Mother’s bed, while the others were staring down at her, as though she were some form of alien curiosity. More than likely they were probably contemplating their *own* eventual mortality. At that moment a strange premonition took hold of me. I suddenly “realized” that *they* would soon suffer the same Fate as my Mother! And sooner — rather than later. — *MUCH SOONER!!!!*

And as if her sudden death hadn’t already been enough of a shock for me, at about 4:30 a.m. two Clinical Assistants (C.A.) — a woman and a large black man — came in and began preparing my Mother for her journey down to the hospital morgue, even while I was still sitting there beside her! The big fellow unfastened my Mother’s wrap-around-diaper and *pulled* it off so hard and so fast that she spun around towards me — and he literally *bashed* the side of her face and head against the solid metal-plate of the bed’s steel guard rails! So hard and so loud that the noise actually woke the patient in the next bed! — I WAS HORRIFIED!! MY BRAIN *COULD NOT COMPREHEND WHAT MY EYES HAD JUST SEEN!!!* “YOU BASTARD!!!! — GET OUT! — GET OUT! — BEFORE I KILL YA!!!!” — I DESPERATELY LOOKED AROUND FOR SOMETHING TO HIT HIM WITH!!!!...

…From start to finish, I saw everything: From that early Friday evening until they killed her on Sunday morning as a result of Sklar changing her CODE; while they all stood around doing nothing! Sklar *purposely*, arbitrarily and *feloniously* countermanded the original **“RESUSCITATE AT ALL COSTS”** order of the ER doctor who asked me — *not once, but twice* — if that’s what I want! “YES! — TO RESUSCITATE! ABSOLUTELY! — AND THAT’S WHAT SHE WANTS!” — I empathetically replied…. I had to sit through two days and nights of pure hell and anguish and witness every single, solitary medical mishap they committed, including the indignity to my Mother’s body *after* her death….

Even the young female mortician, Chelsea Bullard, at *Basic Funerals* asked me, “How did your Mom get that big yellow bump on her face?” …After I told her she was appalled, but not shocked, because of similar horror stories told her by colleagues about ST. MURDER HOSPITAL.

I witnessed it all! On my sweet Mother’s dying breath I swear to you that everything I have described above is the *absolute truth! — SO HELP ME GOD!!!*

…And they even lost my poor Mother's clothes, that little robin-egg blue summer outfit I had dressed her in, on that Fateful Friday morning. I was standing inside the emergency entrance doorways bawling my eyes out, asking the triage nurse for my Mother's belongings. She said: "There's no record here that she came in with anything."

"What? — Whaddya' think they did, bring her in here naked?! I dressed her myself!"

"...Well, there's no record of it here," is all she coolly replied.

I went back outside the emergency doors and stood there, among all the ambulances, beside myself with grief — blinded by my own tears!

Out of nowhere, a young hospital worker, just out having a smoke, I guess, suddenly appeared, and seeing me so distressed asked if he could help. Without any control whatsoever I cried out in anguish everything that had happened since that Friday afternoon and finished with: … — "And my Mother's clothes — they *even* lost my poor Mother's clothes!!"

He said, "Wait here a minute. Let me see what I can do." …

Five minutes later he returned, holding up a transparent plastic bag, and in it I could see my Mother's little blue outfit.

"Is this it?"

"Yes — oh yes! Oh, thank you — thank you so *very* much!" I offered him a reward, but he wouldn't accept it, instead saying softly: "I lost my Mother two years ago, and it still feels like it just happened yesterday…."

I slowly walked out to the street, carrying the last vestiges of my dear Mother's mortal remains. And I thought to myself: "They couldn't even keep track of her clothes. Even *that* they managed to fuck up!" Were it not for that young man, I would have lost them forever, just as I've now lost my Mom… forever.

NO SON SHOULD EVER HAVE TO SIT BY HIS MOTHER'S SIDE AND BEAR WITNESS TO THE PLETHORA OF MEDICAL MISHAPS PERPETRATED AGAINST HER BY A "MEDICAL TEAM" SO UTTERLY AND COMPLETELY INEPT AND INCOMPETENT THAT IT DEFIES THE IMAGINATION! I HAD TO ENDURE THOSE MEDICAL MISFITS OVER THE COURSE OF TWO NIGHTS AND TWO DAYS, DURING WHICH TIME SHE

SUFFERED THE AGONIES OF HELL IN THAT TERRIBLE PLACE!!!! DANTE'S INFERNO COULD NOT HAVE BEEN WORSE!

MY MOTHER ENTERED ST. MURDER HOSPITAL REASONABLY HEALTHY EARLY ON FRIDAY EVENING, AND WAS CARRIED OUT DEAD ON SUNDAY MORNING…. I WILL NEVER BE THE SAME AGAIN….

Sir Anthony Lonsdale-Carr

aka Anthony Heughan

P.S. — I love you, Mom.

(The Bitterest Graveside Tears Ever Shed, Surely Must
Be By Those Who Never Said: "I Love You, Mom.")
ANTHONY CARR

P.P.S. — I spent two years at the Centre for Training in Psychotherapy (CTP), under the watchful eye of forensic psychiatrist Dr. Basil Orchard and his team of psychologists. And this — coupled with a decades-long career as a psychic medium, counseling thousands, including laypeople, professionals, European and Hollywood royalty — has endowed me with a unique and certain instinct to sense when something — or *someone* — is off the mark. So when I state that "Dr." Michael Sklar — (along with his murderous cohorts: "Dr." Seema Marwaha and that vicious Clinical Assistant [C.A.] who bashed my dead Mother's head and face against the metal plate and steel bars attached to her death bed) — thoroughly enjoyed my anguish, as he repeated, ***right up in my face!*** — over and over — and each time louder than the last: — "**WELL, YOUR MOTHER'S DYING!!**" — you had *bloody well better believe me* when I say that Sklar is a sadistic bastard of a psychopathic sociopath! But *he hides it well.* And yet his sardonic grin and tone of voice ***reeks*** with the stench of schadenfreude!!!! As well, that so-called Patient Relations "Expert," Samantha Edgar, will not release to me the name and address of that "man" who calls himself a C.A., in order that he can be served with court papers.

COLLEGE OF PHYSICIANS
AND SURGEONS OF ONTARIO (CPSO)

OR, A MORE TRUTHFUL ACRONYM…

COCKSUCKERS OF PHALLUSES
AND SODOMITES OF ONTARIO (CPSO)

Dear "Members and Malakas" (...*malakes*: from the Greek, loosely translated: "wankers" and "jerk-offs"):

You're a good-for-nothing aggregate of gelatinous, gutless, spineless cowards and murdering co-conspirators who *are* as useless as tits on a bull — even less so, if that's possible. For the better part of a year, you were in possession of my nine-page epistle of anguish and pleas — begging you to help bring me some small measure of justice and personal satisfaction for the deliberate and premeditated murder of my beloved Mother by the above named *quack* "doctors" — Michael Sklar and Seema Marwaha of Toronto's ST. MURDER HOSPITAL! (aka St. Michael Hospital) — and for the indignity to her body, post mortem, by the black male C.A. — (a Clinical Assistant whose name ST. MURDER HOSPITAL'S Patient Relations "Specialist", Sam Edger — a woman — will not release to me). This C.A. *smashed* the side of my Mother's face and head against the steel bars and the metal plate attached to her hospital bed, in his great haste to leave the death room! He tore off her wrap-around body diaper so hard and so fast that she spun — like a top — over to my side of her bed where he crushed her head and face against that steel plate — SO LOUDLY — that the male patient in the next bed suddenly woke, startled and panicked!

Michael Sklar – <u>MURDERER!</u>

Seema Marwaha – <u>MURDERER!</u>

Police Report Number: 24-1621628

The criminal charges against these three "caregivers" are now in the hands of the ONTARIO CRIMINAL COURT OF JUSTICE (CRIMINAL CODE) and are as follows, respectively: "HOMICIDE WITH MALICE AFORETHOUGHT" and for the indignant trauma to my Mother's mortal remains: "INDIGNITY TO A HUMAN BODY!"

Enclosed herein is the original nine page epistle that I personally hand-delivered to the CPSO followed — nearly a year later! — by the responses to me from those two so-called "doctors" — (and from the "College" itself) — on pre-printed, template letters copied by the thousands in *exactly the sam*e style and *manner* — a reflection of each other, word for word; the kind lawyers and real estate agents use. Purchased by the "College" they are sent out to the emotionally exhausted, suffering survivors who now have to face the harsh cruelties of this world all *alone*, thanks to murderous doctors and C.A.s like the above mentioned. Duplicate letters — *right* down to the last period! All they did was add the pertinent names to make them appear official…. Something like the junk mail that finds its way to your mailbox or gets stuffed through your door slot.

My dear friend, the last part of this epistle is specifically ***for you***. Probably you are suffering grievously over the loss of a loved one as a result of the complete incompetence of sociopathic "doctors" like these, who hide their murderous instincts behind a "medical" degree. It leaves a never-ending anguish of pain in the place where your heart and soul once peacefully resided, before these monsters reached in and ripped them out!

SO PLEASE! — PLEASE!! DO NOT EVER — *EVER* THINK ABOUT CONTACTING THE CPSO FOR HELP, BECAUSE AT THE END OF THE DAY AND AT THE END OF YOUR ANTICIPATED RAINBOW, I CAN ASSURE YOU THERE WILL BE NOTHING EXCEPT *MORE PAIN, FRUSTRATION,* HEARTACHE AND DISAPPOINTMENT THAN YOU NO DOUBT ARE ALREADY SUFFERING! (...IF THAT'S AT ALL POSSIBLE…). AS POLICE "INVESTIGATE" POLICE, SO IT GOES WHEN DOCTORS "INVESTIGATE" DOCTORS…. BOTH LIVE BY THE SAME CODE: — CLOSE RANKS AND PROTECT EACH OTHER BECAUSE "**TO SERVE AND PROTECT**" REALLY MEANS "TO SERVE OURSELVES AND PROTECT OUR PENSION FUNDS."

THE CPSO'S OATH IS SLIGHTLY DIFFERENT IN THAT IT'S GONE FROM ITS ORIGINAL *HIPPO**CRAT**IC* OATH: "*FIRST*, DO NO HARM!" TO ITS NEW *HYPO**CRIT**IC* OATH: WHICH IS TO "JERK-OFF EACH OTHER UNDER THE TABLE WHILE SIMULTANEOUSLY DISSEMINATING LYING MEDICAL GOBBLEDEGOOK AND DOUBLE-TALK TO HEART-BROKEN INDIVIDUALS DESPERATELY SEEKING OUR HELP!...

"BUT ALSO, AND MORE IMPORTANTLY, WE *THE COMMITTEE*, WILL ASSURE EACH OTHER THAT WE WILL ALWAYS — BUT ALWAYS — BE RIGHT THERE, LIKE *JOHNNY-ON-THE-SPOT*, TO ENSURE THAT OUR BIG, FAT, MONTHLY PAY CHEQUES, PENSIONS, AND ROYALTIES LAND SQUARELY IN THE MIDDLE OF OUR FAT, GREASY, GREEDY, SWEATY LITTLE PALMS ON SCHEDULE, AND TO HELL WITH ALL THE LITTLE PEOPLE OUT THERE BECAUSE WE REALLY DON'T GIVE A SHIT ABOUT THEM, ANYHOW — JUST AS LONG AS *WE'RE* OKAY!"...

BUT VERILY I SAY UNTO THEE: OH! — YOU LIARS, HYPOCRITES AND WOLVES IN SHEEP'S CLOTHING! YOU HAVE GOT YOUR NOSES STUCK SO FAR UP EACH OTHER'S ASSHOLES THAT I'M SURPRISED YOU HAVEN'T CHANGED YOUR "COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO" ACRONYM (CPSO) TO (RBNR): "RUDOLPH THE ***BROWN-NOSED*** REINDEER(S)"!

BUT YOUR DAY IS COMING — AND SOON! ALL OF YOU WHO ARE RESPONSIBLE FOR MY MOTHER'S HORRENDOUS MURDER AND COVER-UP WILL BE RUNNING AND SHRIEKING AND HIDING FROM THE WRATH OF THE HOLY TERROR THAT SHALL DESCEND FROM THE HEAVENS LIKE THE MIGHTY HAMMER OF THOR! — WITHOUT WARNING!!!!

NOT YOUR WEALTH, NOR YOUR MANSIONS AND PALACES, NOR YOUR SOCIAL STATUS IN THE WORLD WILL SAVE YOU! — AND SO SHALL IT BE FOR ALL THE INHABITANTS OF THE EARTH WHO FOLLOW YOU! *THIS GENERATION* HAS BECOME AS SODOM AND GOMORRAH — (ON STEROIDS!)

NO PLACE TO HIDE — YOU WILL RUN — SCREAMING AND SQUEALING LIKE STUCK PIGS! BUT TO NO AVAIL…. YOU WHO HAVE SHOWN NO MERCY SHALL RECEIVE NONE!… IF ONE WERE TO CONFLATE COVID, 9-11 AND SOON WWIII — WHICH IS NOW ON YOUR DOORSTEP! — IT WILL SEEM AS "A STROLL IN THE PARK" COMPARED TO THE COMING TERRIBLE TRIBULATION, TOO HORRIBLE TO CONTEMPLATE — AND TOO SUDDEN TO AVOID!!!! YOU WHO HAVE PUT YOUR WORSHIP OF THE GOLDEN IDOL ABOVE THE CARE OF YOUR HELPLESS BRETHREN — THE WEAK, THE INFIRM — AND EVEN THE *MURDER* OF THEM!!!! — IS *TRULY* THY GREATEST SIN!!!!

"...GREATER LOVE HATH NO MAN THAN THIS, THAT HE LAY DOWN HIS LIFE FOR ANOTHER.…" (JESUS CHRIST) — WHICH MY MOTHER DID MANY TIMES DURING WORLD WAR Ⅱ!!!! — AND AS DID THOUSANDS OF OTHER VETERANS THAT YOU PROBABLY MURDERED!!!!

…BUT ON THAT DAY OF HOLY TERROR, WHEN THE MESSIAH DESCENDS WITH HIS CELESTIAL HOSTS, THEN SHALL *ALL* THE "GODS" BE AS ***ONE!* — HIM!! — *THEM!!! — AND THEY SHALL COME IN CLOUDS!!!!***

LEST YOU THINK *ME* A FOOL, REMEMBER YOUR SCRIPTURE: ... "GOD PUTS THE FOOLS IN THIS WORLD TO CONFOUND THE "WISE". (CHRISTIAN BIBLE AND QUR'AN).... REMEMBER ALSO THAT THE PEOPLE LAUGHED AND SCOFFED AT NOAH AS HE BUILT HIS GREAT ARK AND WARNED THEM OF THE COMING DELUGE!

AND *THIS* FOOL'S DECADES-LONG — *PUBLISHED* — RECORD OF ACCURATELY *FULFILLED* GLOBAL PROPHECIES WILL BEAR WITNESS TO MY WORDS:...THE GREAT BIBLICAL FLOOD, THE TEN PLAGUES OF EGYPT TOOK PLACE IN THE YEAR (CIRCA) 2025 *BCE* (*BEFORE THE COMMON ERA*). AND HERE WE ARE: 2025 AD (ANNO DOMINI — ***THIS*** COMMON ERA!!!!).

MOST DIS-RESPECTFULLY YOURS, SIR ANTHONY LONDSALE-CARR. (A.K.A. Anthony Carr, Anthony Heughan)

CC TO: **HPARB — HEALTH PROFESSIONS APPEAL AND REVIEW BOARD:**
(CPSO's partner in crime!)

OR THEIR MORE TRUTHFUL ACRONYM…

HYPOCRITICAL PUSSY ASSHOLE RETROUSSÉ BOORS!

The War Amps — Ontario Key Tag Service November 5, 2024

1 Maybrook Dr
Scarborough, ON
M1V 5K9

*Michael Sklar — **MURDERER!***

*Seema Marwaha — **MURDERER!***

Police Report Number: 24-1621628

Dear Veterans:

This donation is made in loving memory of my dear Mother, Josephine Heughan (nee Lonsdale), and other WWII — and WWI — members of my family; to wit: Josephine Lonsdale (Heughan), serial no: W20167 — who was murdered *purposely* by two so-called doctors at Toronto's "ST MURDER HOSPITAL!" (a.k.a. St Michael Hospital). Their names: "Doctors" Michael Sklar and Seema Marwaha. I am presently in the process of having them charged with "Homicide with Malice of Forethought" — along with the Clinical Assistant (C.A.) who will be charged with "Indiginity to a Human Body" — which immediately followed her death by MURDER!!!! (He *bashed* the side of her face and head against the hospital bed's steel bars and metal plate when he whipped off her diaper — because he was in a hurry to leave!) Even the young female mortician was appalled, and said: — "What happened to your Mother's face?!"

The ambulance and I took her to St. Murder Hospital on a Friday afternoon and she was dead early Sunday morning, July 23rd, 2023, 2:20 a.m. I witnessed it all!!! I am writing this note to warn — not only surviving Veterans — but the elderly, in general. As the police band together to protect each other of any wrong doing, so do incompetent "doctors". It's all about money!! They say "People are living *too long* without contributing to the economy," and thus, the word has gone out that at a certain age: — 70, 80, 90, 100 — "just let them die so the hospital can get more money!" The same goes for Police Departments: "To Serve And Protect"... Translation: "To Serve Ourselves And To Protect Our Pension Fund." It's a well-known fact that cops don't get promoted unless they bring back to the station-house a certain quota of tickets. Which is another reason why they started hiring metermaids.

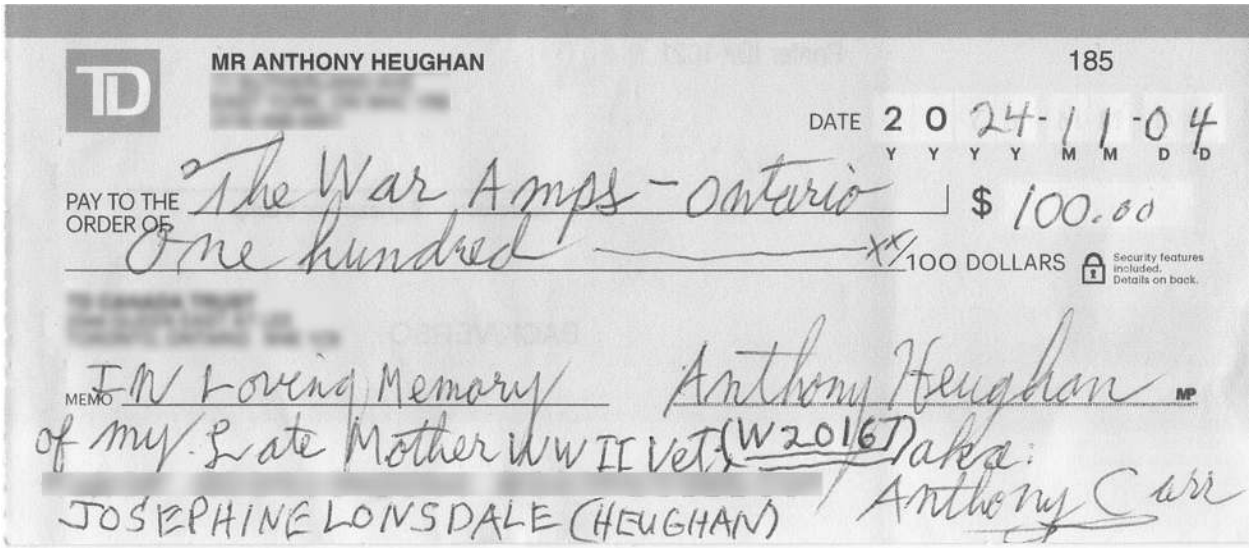
I was a feature writer with The Toronto Sun for over 50 years! — also a free-lancer with The Toronto Star and The National Post…. I took over the syndicated column: "The Unexplained," created by the late, great Allen Spraggett — followed by my own "Hands of Destiny" (The Book of Palms) series. I've worked with the late Gordon Sinclair, Ted Reeve, et al — on and on, ad infinitum et ad nauseum. Therefore, I know of where I speak:

And now, the late honoured members of my military family: Peter Lonsdale, WWI Veteran, served at Vimy Ridge, France, and Father of *my* WWII Veteran Mother, Josephine Heughan (nee Lonsdale), serial no: W20167; and her sister, my Aunt "Dixie," Daisy Vivian Ponzo (nee Lonsdale), serial no: W20166; and finally, my uncle Hubert "Herb" Lonsdale: WWII, served in North Africa against the might of German Field Marshall Erwin Rommel's (known as the "Desert Fox") — powerful tank divisions; then to Italy and straight into the uphill battles of Monte Casino and Ortona!

And *this* is how we let the medical profession treat the saviors of our Democracy?!! Shame!-Shame on them! But Shame!-Shame!-Shame on *US* for just standing by and allowing it to happen!!!!

Yours, very *very* truly,
Sincerely,
Sir Anthony Lonsdale-Carr (a.k.a Anthony Carr / Anthony Heughan)

To see and read more, go to www.anthonycarrpsychic.com



Gmail

Anthony Carr <info@anthonycarrpsychic.com>

Follow up of your concerns

Patient Relations SMH <patientrelationsSMH@unityhealth.to> Tue, Nov 7, 2023 at 4:21 PM
To: "info@anthonycarrpsychic.com" <info@anthonycarrpsychic.com>

Hello Mr. Carr,

I am writing in follow up to our meeting held on September 20th, 2023 to address the concerns you expressed about the care provided to your mother (Ms. Josephine Heughan), during her hospital admission from July 21st, 2023 to July 23rd, 2023.

We recognize it is important to have your questions and concerns addressed, regretfully we were unable to address them in full as the meeting ended early. Please find attached to this email a letter outlining our review and follow up to your concerns.

We hope that this letter serves to provide clarity regarding your mother's care and treatment. Should you have questions regarding the feedback provided, you may contact me directly at patientrelationsSMH@unityhleath.to.

Sincerely,

Sam Edgar (she/her)

Patient Relations Specialist

ST. MICHAEL'S
UNITY HEALTH TORONTO

T: 416-864-5215| F: 416-864-5509 |E: patientrelationsSMH@unityhealth.to

J. Heughan - Response Letter for A. Carr - November 7th 2023.pdf
268K

ST. MICHAEL'S
UNITY HEALTH TORONTO

Caring hearts. Leading minds.

November 7th, 2023

Delivered by email

Dear Mr. Carr,

I am writing in follow up to the concerns you expressed about the care provided to your mother (Ms. Josephine Heughan), during her hospital admission from July 21st, 2023 to July 23rd, 2023. On behalf of the care team I would like to again offer our heartfelt condolences to you on your mother's passing. We recognize this has been a very significant loss for you and we are sorry for the grief you are experiencing.

YWE CAUSED you!!!! (AC)

As you are aware, a meeting was arranged on Sept 20th, 2023 to address your concerns. Present at the meeting were Sam Edgar (Patient Relation Specialist), Dr. Seema Marwaha (Staff physician, General Internal Medicine), Dr. Michael Sklar (Staff Physician, Critical Care) and Norman Dewhurst (Clinical Lead Manager, General Internal Medicine). Regretfully the meeting was ended early due to disrespectful language that was exhibited toward the leaders and physicians in attendance.

(DISRESPECTFUL LANGUAGE WELL DESERVED!!!! (AC)

We do recognize that this is a very difficult time for you and that it is important to have your questions and concerns addressed. While we were unable to address these through an in-person meeting we have taken the time to outline our review and follow up in this letter.

I understand from our conversations you have questions about care decisions made in the Emergency Department (ED) and the General Internal Medicine (GIM) Department, regarding why a CT scan was not performed as well as concerns about communications surrounding your mother's code status.

I want to assure you that we take your concerns very seriously, and upon hearing your concerns about the care provided to your mother and communication from staff, they were brought forward to the leadership of the ED and Medicine unit for review. A thorough and comprehensive review of the event has been completed, including a chart review, and discussions with staff and physicians involved. Below we have summarized our feedback in writing in response to your concerns.

With regards to the Emergency Department care, Dr. Chu has shared that based on her initial clinical assessment in the ED, your mother's condition was such that she did not need a CT of the abdomen at that time. It is documented that her abdomen was soft, not swollen beyond it's normal size and her vital signs were stable. It was noted however she was dehydrated so intravenous fluid was ordered and she was referred to the GIM team for admission and further work up.

AFTER A 7 HOUR WAIT

AFTER THE 7 HOUR WAIT THEN

Dr. Marwaha, internal medicine physician, then assessed your mother. At the time of Dr. Marwaha 's assessment, she found your mother's abdomen to be ridged and swollen beyond its normal size and an urgent XRAY was ordered which showed she had a bowel obstruction. In response Dr. Marwaha inserted a nasogastric (NG) tube to relieve pressure in the abdomen, and feculent matter was suctioned from your mother's stomach. The medicine team provided more IV fluids, initiated a bowel rest protocol, administered IV antibiotics and ordered an urgent CT scan at that time. They also spoke directly with the general surgery service to request a consultation.

NOT TRUE!!!! (AC)

INTERIM OF NOTHING BEING DONE (WHILE WE WAITED IN THE HALLWAY!!!!) (AC)

Your mother was transferred up to the medicine unit shortly afterwards, where unfortunately her condition started to quickly decline. Dr. Marwaha shared that your mother's blood work appeared much worse with a lactic acid level of 10 (normal range being 2 and below) indicating that her muscle tissues

ST. MICHAEL'S
UNITY HEALTH TORONTO

Caring hearts. Leading minds.

were not receiving enough oxygen and she was in multi system organ failure, therefore too unstable to be moved. The Critical Care Response Team (CCRT) and the Intensive Care Unit (ICU) attending physician urgently reviewed her situation with the general surgery team to determine if surgery was an option. Unfortunately it was determined that your mother was critically ill to physically move to the CT scanner or receive surgical intervention. Palliative care services was consulted and saw your mother later in the day.

We understand from your feedback that it was not clear to you that CPR (cardiopulmonary resuscitation, also known as chest compressions) would not be offered to your mother and the reason why. We sincerely apologize for this and any distress to you as a result. Dr. Sklar informed me that he spoke with you regarding your request for CPR and he is sorry to hear that his communication was not clear to you. Dr. Sklar has explained that CPR does not work for all patients and that due to your mother's critical condition, frailty and age, CPR would not be successful for your mother and would not result in her resuscitation. CPR is not offered when it has no potential benefit to the person and when the performance of CPR will cause more harm and indignity to the patent. The do not resuscitate (DNR) order prevents the automatic urgent institution of chest compressions. Every patient and person is evaluated individually, and the person's status determines what options might provide benefit in each individual case.

We wish to acknowledge the concerns you shared regarding communication from the nursing staff on the medicine unit the night your mother passed. You shared that the staff would not provide CPR when your mother ceased breathing. As your mother's code status was documented to not perform CPR, the nursing staff were following the medical team's orders. I am sorry for any miscommunication from the staff when they explained why they were not performing CPR on your mother, and if their communication lacked compassion or came across as dismissive or lacking urgency.

We regret to hear of your concerns relating to the staff who provided post mortem care to your mother. You shared the staff member was not careful when providing care, resulting with her head connecting with the side rail. We strive to ensure the utmost respect and dignity for care after death and are sincerely sorry for your experience. Please be assured there has been follow up with staff regarding your feedback.

We hope that this letter serves to provide clarity regarding your mother's care and treatment. Should you have questions regarding the feedback provided, you may contact me directly at patientrelationsSMH@unityhleath.to. As an organization we are committed to ensuring a safe environment where staff and patients alike are treated with respect and dignity and it is our expectation that moving forward all communications be conducted in a respectful manner.

Sincerely,

Sam Edgar (she/her)

Patient Relations Specialist

—AFTER 15 HOURS OF VIRTUALLY NO TREATMENT AND OF COURSE—AFTER NEARLY TWO DAYS OF NO FOOD OR DECENT TREATMENT!!! (AC)

I KNOW THE REASON WHY! IT'S YOUR UNWRITTEN LAW TO KILL OFF SENIORS TO SAVE MONEY!! —THAT'S WHY!!!! (AC)

"DR." SKLAR IS A CLOWN AND A SADIST CLOAKED IN A "MEDICAL DEGREE!"

HE COMMICATED NO SUCH INFORMATION TO ME, OTHER THAN TO KEEP YELLING— AT THE TOP OF HIS LUNGS— THAT "WELL YOUR MOTHER'S DYING!!"

"CONNECTING WITH THE SIDERAIL" (WHAT A BULLSHIT EUPHEMISM!!? (AC)

I KNOW, BECAUSE I HAVE BEEN STUDYING —AND TREATING— THERE IS DEFINITELY SOMETHING WRONG WITH THIS GUY! HE NEVER TOLD ME HE WANTED TO SWITCH TO A DNR BECAUSE HE—AND MARWAHA—BOTH KNEW THAT I WOULD NEVER AGREE TO SUCH A HORRIFIC PROCEDURE!!!!

SCREWED-UP PEOPLE LIKE SKLAR FOR OVER 60 YRS.!!! (Anthony Carr)

Gmail

Anthony Carr <info@anthonycarrpsychic.com>

Response to your concerns

Patient Relations SMH <patientrelationsSMH@unityhealth.to> Fri, Dec 22, 2023 at 3:43 PM
To: "info@anthonycarrpsychic.com" <info@anthonycarrpsychic.com>

Dear Mr. Carr,

We are following up in response to your voice mail received on Thursday December 21st at 1:30pm. You have requested the name of the Porters responsible for providing post mortem care to your mother after her passing on July 23rd 2023. In light of the inappropriate and threatening behavior that you have demonstrated during your interactions with staff, we will not be providing this information to you at this time. Unity Health Toronto is committed to providing a safe, healthy and supportive working environment and to the prevention of workplace violence. The College of Physicians and Surgeons is able to contact us directly for that information. We have standard processes for releasing information to the College, and do provide them with any information they require for their investigations.

You have indicated that if the information is not released to you directly, you intend to have your lawyer obtain this on your behalf. Your lawyer can submit the relevant documentation to support this request to Risk@unityhealth.to, and we will respond accordingly. We have now completed your Patient Relations file on this matter.

Again, we recognize this has been a very significant loss for you and offer our sincerest condolences on the your mothers passing.

Sincerely,

Patient Relations

ST. MICHAEL'S
UNITY HEALTH TORONTO

T: 416-864-5215| F: 416-864-5509 |E: patientrelationsSMH@unityhealth.to

2023/12/26

St. Michael's Hospital
Patient Care Department
Email address: patientrelationsSMH@unityhealth.to
30 Bond St.,
Toronto, ON
M5B 1W8

To whom it may concern,

I am writing to you concerning, not only the email that you sent to Mr. Anthony Carr dated 2023/12/22, but also in regard to the physical meeting that we had with members of your care team. I attended that meeting with Mr. Carr and as such have first-hand knowledge of what transpired. My interest in this series of events is three-fold; as someone who knew Josephine Victoria Lonsdale Heughan personally, as a long-time friend of Anthony Carr and in a general sense of trying to assist people to have better, more productive lives in which they are treated with respect and compassion (the latter being the reason that I ran to be Mayor of Toronto in the 2023 elections and placed in the top ten in many areas of the city).

I wish to make a direct response to your comment "In light of the inappropriate and threatening behavior that you have demonstrated during your interactions with staff, we will not be providing this information to you at this time.". This is regarding the request for information about the Porter(s) who did not show the proper respect to Mrs. Heughan's body (thereby allowing her head to "connect with the rail" when they were removing her body from the bed). Anthony Carr was in no way "threatening" to anyone at that meeting, nor after it. If your reference is to the fact that he used his cane to point in the general direction of a member of your staff (someone that he was certainly not within reach of) I made it quite clear ***at that time*** that he was doing no more than just indicating who he was speaking about.

As far as "inappropriate" behaviour, as Mr. Carr was obviously and understandably ***very*** upset by the loss of his mother, it should be expected by your experienced team that he would not sit quietly and be told how you were "sorry for [his] loss", especially seeing as your staff did the exact opposite of what was instructed of them regarding her care. This included that she be "resuscitated at all costs" and Dr. Sklar believing that he had the right to change that to DNR (Do Not Resuscitate). The mistakes they made, on or about 2023/7/23 were irreversible, and could be perceived to have been done to make sure that they no longer had responsibility to keep Josephine alive. Once she was dead, they seemed to believe that their duties ended. Further, just because Josephine Heughan had passed away, there was no reason for the Porter(s) to believe that she did not merit their respectful handling of her physical self. You have stated in your email that "Unity Health Toronto is committed to providing a safe, healthy and supportive working environment and to the prevention of workplace violence." The handling of Anthony's mother's body, the smashing of her face against the bed rail, is clearly an act of violence.

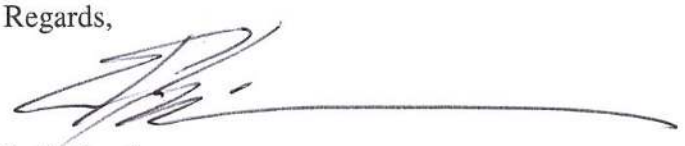
The family does not wish to sit idly by to wait for an eventual investigation by The College of Physicians and Surgeons, but believes that it should be actively pursued. To suggest that you

"... have now completed your Patient Relations file on this matter" would appear to be somewhat premature, so please keep apprised of the process. Your part is certainly unfinished as of yet. Please indicate details on exactly what "relevant documentation" is required so that Anthony's lawyer can submit the request to Risk@unityhealth.to regarding the Porter(s) who mishandled Josephine's mortal remains.

It is interesting to note that your closing statement was "Again, we recognize this has been a very significant loss for you and offer our sincerest condolences on the your mothers passing." which appears to be a form letter response gone wrong, and is less than sincere. You might wish to have someone edit your email for spelling and grammatical errors going forward.

Thank You.

Regards,



L. B. Sanders
(647) 712-7283
LBSanders@Teachers.org

Gmail Anthony Carr <info@anthonycarrpsychic.com>

College of Physicians

Tanya Tazbaz <ttazbaz@cpso.on.ca> Fri, Nov 24, 2023 at 11:45 AM
To: "info@anthonycarrpsychic.com" <info@anthonycarrpsychic.com>

Hello Sir Anthony Lonsdale-Carr,

The College has received your complaint.

I would like to further discuss this matter with you.

Are you available for us to connect by phone on Monday November 27, 2023 at 11AM?

If not, please suggest your preferred availability.

Regards,

Tanya Tazbaz

Triage Investigator/Mediator: Investigations and Resolutions

The College of Physicians and Surgeons of Ontario

80 College Street | Toronto, Ontario | M5G 2E2

T: 416-967-2600 | 1-800-268-7096 ext. 516

T : 416 968 5447 (direct)

Fax: 416 967 2616

ttazbaz@cpso.on.ca

CAS-454033-X8L4J8

Jennifer Matheson-Watson <jmathesonwatson@cpso.on.ca> Mon, Jan 8, 2024 at 12:22 PM
To: Anthony Carr <info@anthonycarrpsychic.com>

Hello,

Yes, I can confirm the investigation is on-going. I am attaching the information process regarding timelines. I have all required information from you at this time.

Sincerely,

Jennifer Matheson-Watson, Investigator, Investigations and Resolutions

T: 416-967-2600 | 1-800-268-7096 ext. 377; F: 416 967-2616

Email: jmathesonwatson@cpso.on.ca

From: Anthony Carr <info@anthonycarrpsychic.com>
Sent: Friday, January 5, 2024 8:17 PM
To: Jennifer Matheson-Watson <jmathesonwatson@cpso.on.ca>
Subject: Re: Response from St. Mike's on Josephine Heughan case

Hi Jennifer,

Anthony was wondering if you could send us an email that would confirm that you are indeed investigating the case.

Anthony's phone number: 647-231-2001

Thank you,

Justin

In reply please quote: **CAS-454033-X8L4J8**

January 8, 2024

PRIVATE AND CONFIDENTIAL
Sent via secured electronic means.

Dear: Mr. Anthony Carr

Re: Complaint Regarding Dr. Marwaha and Dr. Sklar

On December 8, 2023, the following concerns were confirmed verbally:

Mr. Anthony Carr is concerned that between July 21, 2023, and July 23, 2023, Dr. Michael Sklar was negligent in the care provided to his late mother Ms. Josephine Lonsdale Heughan. Specifically, Dr. Sklar;

> ***a) Failed to inform Mr. Carr that a do not resuscitate order had been written for his mother, against his wishes and without his consent.***
> ***b) Did not communicate information regarding Ms. Josephine Heughan's condition or prognosis.***
> ***c) Delayed ordering a CT scan to rule out a bowel obstruction until Ms. Heughan wa too sick to have it done; she was admitted for vomiting, abdominal distention and an x-ray identified blockage.***

Mr. Anthony Carr is concerned that between July 21, 2023, and July 23, 2023, Dr. Seema Marwaha was negligent in the care provided to his late mother Ms. Josephine Lonsdale Heughan. Specifically, Dr. Seema Marwaha.

> ***a) Failed to inform Mr. Carr that a do not resuscitate order had been written for his mother, against his wishes and without his consent.***
> ***b) Did not communicate information regarding Ms. Josephine Heughan's condition or prognosis.***
> ***c) Delayed ordering a CT scan to rule out a bowel obstruction until Ms. Heughan was too sick to have it done; she was admitted for vomiting, abdominal distention and an x-ray identified blockage.***

Signed consents were returned to the College on December 8, 2023.

I am also enclosing information about signing consent to help you understand why the Inquiries, Complaints and Reports Committee requires consent.

The CPSO has a duty of confidentiality with respect to all information obtained in the course of its investigation. However, you should be aware that the CPSO may share some or all of your personal health information with the physician or physicians who are the subjects of the complaint. If either you or the physician appeals the College's decision, medical information and other information collected during the investigation must be disclosed to the Health Professions Appeal and Review Board, which is a public forum.

Power of Attorney documents were received by the College on December 6, 2023.

Under the legislation, the subject physician has been notified of your complaint. Once all the necessary information is received, the Inquiries, Complaints and Reports Committee (ICRC) will review the information and decide whether further action is needed. Please note the Committee is not permitted to award financial payments through the complaints process.

The College recognizes how stressful this process can be and will make every effort to proceed quickly. However, there are a number of external factors that can slow this process down such as, obtaining and analyzing medical records and obtaining other relevant information. Your patience is appreciated.

Sincerely,

(*Signed Electronically*)
Jennifer Matheson-Watson, Investigator, Investigations and Resolutions
T: 416-967-2600 | 1-800-268-7096 ext. 377; F: 416 967-2616
Email: jmathesonwatson@cpso.on.ca

In reply please quote: CAS-454033-X8L4J8

April 12, 2024

Sent via email
PRIVATE AND CONFIDENTIAL

Mr. Anthony Lonsdale-Carr

Dear Mr. Lonsdale-Carr:

Re: Your Complaint

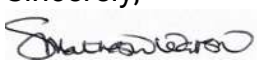
This is to inform you that the Inquiries, Complaints and Reports Committee (the Committee) will assess and review your complaint at a meeting on April 24, 2024. The Committee does not meet directly with you or the physicians.

You will receive the Committee decision within 4-6 weeks of the meeting. Please be aware that staff cannot release the decision before then. In the rare event that the Committee defers their decision, we will contact you.

We will provide the Committee decision to you by secure email unless you inform us otherwise. Please inform me immediately of any change to your email address.

If you have any questions, please contact me.

Sincerely,



(*Signed Electronically*)
Jennifer Matheson-Watson, Investigator, Investigations and Resolutions
T: 416-967-2600 | 1-800-268-7096 ext. 377; F: 416 967-2616
Email: jmathesonwatson@cpso.on.ca
JMW/am

Gmail

Anthony Carr <info@anthonycarrpsychic.com>

CAS-454033-X8L4J8

Jennifer Matheson-Watson <jmathesonwatson@cpso.on.ca> Fri, Apr 19, 2024 at 2:06 PM
To: "info@anthonycarrpsychic.com" <info@anthonycarrpsychic.com>

Hello Mr. Carr,

I did see the email reply from Amanda answering the voicemail you left for her, I was on vacation last week; my apologies in the delay responding. The ICRC will be hearing the matter on April 24, 2024. I do not have anything additional to share at this time. Once the decision has been made and written you will receive a copy of decision. If you are not satisfied with the outcome there is an appeal process, I am attaching the information on College process for you to have on hand.

Sincerely,

Jennifer Matheson-Watson, Investigator, Investigations and Resolutions

T: 416-967-2600 | 1-800-268-7096 ext. 377; F: 416 967-2616

Email: jmathesonwatson@cpso.on.ca

Complainants Info.pdf
115K

In reply please quote: CAS-454034-R7K9Q5 [CAS-454033-X8L4J8]

PRIVATE AND CONFIDENTIAL

May 23, 2024

Sent by: Secure Email

Mr. Anthony Lonsdale-Carr

Dear Mr. Lonsdale-Carr:

Re: Complaint Regarding Dr. Michael Chaim Sklar

The Inquiries, Complaints and Reports Committee (the "Committee") of the College of Physicians and Surgeons of Ontario has now considered your complaint. The Committee made its decision after a careful review of all relevant information gathered during the investigation. A copy of the Committee's written decision and reasons is enclosed.

If you believe that the Committee's investigation was inadequate, or its decision was unreasonable, you can request a review by the Health Professions Appeal and Review Board (HPARB). HPARB, a body created by the government of Ontario, is entirely independent and separate from the College.

You must make any request for a review directly to HPARB, and not to the College. Address your request to:

Health Professions Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4
Tel: 416-327-8512 Fax: 416-327-8524 E-mail: hparb@ontario.ca
HPARB website: http://www.hparb.on.ca/

If you are requesting a review, please ensure you include the College file number, the full names of the parties, the ICRC decision and its cover letter**.** Please note that your right to ask for a review expires 30 days after the date you receive this letter.

If either party appeals this decision, HPARB will contact the College to confirm your address. We will provide HPARB with the contact information that you have provided to us during the course of the investigation.

Sincerely**,**

OFFICIAL COPY

The Inquiries, Complaints and Reports Committee

/pmd
encl.

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE
(the Committee)

DECISION AND REASONS

CASE NO.:	CAS-454034-R7K9Q5 (CAS-454033-X8L4J8)
COMPLAINANT:	Anthony Lonsdale-Carr (Son)
PATIENT:	Josephine Lonsdale Heughan
RESPONDENT:	Dr. Michael Sklar
CPSO NUMBER:	98325
SPECIALTY:	Critical Care/Anesthesiology

INTRODUCTION

The Respondent is a member of the Critical Care Response Team at St. Michael's Hospital (SMH), Toronto. The team provides consultation to critically ill patients.

The Patient was admitted to SMH on July 21, 2023 for nausea, vomiting and possible small bowel obstruction.

The Respondent assessed the Patient once on July 22, 2023. The Patient passed away in the hospital the next day at the age of 100 years old.

The Complainant is concerned that between July 21 and 23, 2023, the Respondent was negligent in the care he provided to the Patient. Specifically, the Complainant is concerned that the Respondent:

- **Failed to inform the Complainant that a do-not-resuscitate (DNR) order had been written for the Patient, against the Complainant's wishes and without his consent;**
- **Did not communicate information regarding the Patient's condition or prognosis; and**
- **Delayed ordering a CT scan to rule out a bowel obstruction until the Patient was too sick to have it done. The Patient was admitted to hospital for vomiting, abdominal distention and an x-ray identified blockage.**

At the outset, the Committee wishes to express its sincere condolences to the Complainant on the loss of his mother.

The Complainant also expressed concern about another physician. The Committee will address those concerns in a separate Decision and Reasons.

DISPOSITION

The Committee considered this matter at its meeting of April 24, 2024. For the reasons set out below, the Committee takes no action on this complaint.

ROLE OF THE COMMITTEE

When the College receives a complaint about a physician, the Committee, with the assistance of staff, conducts an investigation. Completed, written records of investigation are presented to panels of the Committee, which meet regularly to review and dispose of these.

When reviewing a complaint, the Committee considers the seriousness and context of the concerns raised, the physician's insight into their practice, their capacity for remediation, and their relevant College history. The Committee seeks to protect patients and, where possible, to enhance the quality of physicians' care or conduct through education and remediation.

The Government of Ontario, through legislation, sets out what the Committee may do after considering a complaint. The Committee may: take no further action; issue advice or state its expectations; require the physician to appear before a panel of the Committee to be cautioned; require the physician to undertake a specified continuing education or remediation program; or take action it considers appropriate that is not inconsistent with the relevant legislation.

The Committee will, in some instances, refer a matter to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT or the Discipline Tribunal) for a live hearing into allegations of professional misconduct or incompetence. This occurs only where the Committee determines that referral to the Discipline Tribunal is in the public interest, and that the available information has a reasonable chance of supporting a successful prosecution. Finally, the Committee may refer a physician for incapacity proceedings.

The Committee cannot award or recommend financial compensation.

The Committee does not determine liability, or whether a physician's action or inaction caused a particular outcome, nor is it the Committee's role to punish physicians.

The Committee appreciates the participation of the Complainant in bringing these concerns to the attention of the College. Public engagement helps the College to protect the public interest and improve the quality of physicians' care. The Committee also acknowledges the Respondent for demonstrating professional accountability in responding to this complaint.

For more information about the role of the College and the Committee, please visit the College's website at www.cpso.on.ca.

INFORMATION BEFORE THE COMMITTEE

The Committee considered the information obtained during investigation of this matter. In most cases, this includes information from both the Complainant and the Respondent, as well as the medical record.

The Committee is bound by legislation and regulations, which are applied in the decision-making process. The Committee also refers to the College's publication, "The Practice Guide", as well as College policies and related guidance documents which reflect the College's professional expectations of physicians practising in Ontario. These documents are available on the College's website. The Committee will provide a copy of any policy referred to in this decision.

As part of its decision-making process, the Committee always considers the physician's history with the College, if any.

ANALYSIS

The Committee considered the following points in reaching its decision:

The Respondent failed to inform the Complainant that a do-not-resuscitate (DNR) order had been written for the Patient, against the Complainant's wishes and without his consent

- In his response, the Respondent indicates that:
  - The general medical team asked him to see the Patient on her second day of admission. He spoke with the most responsible team and reviewed the Patient's condition. The Patient had multiple severe co-morbidities at baseline.
  - He spoke directly with the surgeon on call to ask that they review the Patient for possible surgical candidacy. Their assessment, similar to his own and that of the general medical team, was that the Patient was dying and even if she had a condition that was amenable to surgery, the Patient would not tolerate any potential operation as there was an unacceptably high likelihood that she would die in the operating room.
  - He informed the Complainant that the Patient was dying and that further resuscitative efforts would not be warranted due to excess harm without benefit and therefore would not be attempted. The Complainant acknowledged this and did not dispute his recommendation that resuscitative efforts would not be attempted. This was reiterated to the Complainant by the other medical and surgical teams as well.
  - The decision whether or not to offer administration of life support is made by the physician, who has a duty to offer or recommend only those treatments that may pose some potential benefit for the patient.
- The medical records indicate that the care plan was based on the clinical presentation of the Patient, who had multiple co-morbidities and was at end-of-life. The Patient presented to the Emergency Department with nausea, vomiting, hypotension, and hypovolemia. She had a bowel obstruction and acute kidney injury. She received treatment with volume replacement, supplemental oxygen, a nasogastric tube and antibiotics. Multiple health teams assessed the Patient and unanimously felt the risk of further invasive measures, including transport to a CT

scanner and surgery, would not change the outcome and could potentially prolong the Patient's suffering. It is documented that this was communicated to the Complainant, and that he understood and agreed with this plan.

- As such, the records support that the Respondent informed the Complainant that the Patient was at end-of-life and further invasive measures would cause more harm than benefit, and the Complainant agreed. In the absence of convincing evidence to the contrary, the Committee is satisfied that the contemporaneous medical record is a reliable source of information as to what occurred.

The Respondent did not communicate information regarding the Patient's condition or prognosis

- The records satisfy the Committee that the Respondent and the Patient's healthcare team shared information regarding the Patient's condition and prognosis with the Complainant on multiple occasions. There are several documented discussions with the Complainant. The Committee notes that it "appears" from the record that the Complainant received information regarding the Patient and was involved in the Patient's care.

The Respondent delayed ordering a CT scan to rule out a bowel obstruction until the Patient was too sick to have it done; the Patient was admitted to hospital for vomiting, abdominal distention and an x-ray identified blockage

- The Respondent indicates that he cannot comment on the events that occurred before he was consulted to see the Patient. When he was first involved in the Patient's care, a CT scan had been ordered and the Patient was near the end of life. A transport to the CT scanner was unsafe as there was a serious risk that the Patient would die in transport. The Respondent recommended that the general medical team carefully weigh the risks versus benefits of proceeding with the pending CT scan. The internal medicine team agreed.
- The Committee notes that the Respondent did not order the CT scan, and as previously stated, multiple health teams, including the Respondent, assessed the Patient and unanimously felt the risk of further invasive measures, including transport to the CT scanner and surgery, would not change the outcome and could potentially prolong the Patient's suffering. As such, it was reasonable for

The first 3 paragraphs of this page are the only truths spoken in these 6 pages and of lies obfuscations!

the Respondent to determine that a CT scan transport would be unsafe for the Patient.

1. Overall, the Committee is of the view that the Respondent provided reasonable and appropriate care for the Patient and will take no further action on this complaint.

Non-disclosure of Committee Members' Names

- In reviewing the investigative file, the Committee observes that the Complainant has repeatedly made inflammatory and threatening remarks towards the Respondent and hospital staff. This includes the dissemination of photographs of the Respondent on public online platforms. The Complainant informed the College that he plans to "blacken the doctors' reputations", and that the physicians "will wish they were dead".

- Furthermore, the Complainant left an exceptionally high volume of inflammatory and threatening voicemail messages for the College. The Complainant shares his intention to post the Committee's decision publicly and noted that there would be a "rude awakening" if the College takes no action.

- The Committee is concerned by the Complainant's statements and believes, in the interests of safety, that it would be reasonable in this case not to disclose the identities of individual panel members. This is an infrequent occurrence, although nothing in the Code requires that the names of panel members be disclosed. In the circumstances, the Committee believes it is reasonable for panel members to remain anonymous. This matter was considered by a panel of the Committee consisting of three physicians and one public member.

In reply please quote: CAS-454036-H3D6Y2 [CAS-454033-X8L4J8]

PRIVATE AND CONFIDENTIAL

May 23, 2024

Sent by: Secure Email

Mr. Anthony Lonsdale-Carr

Dear Mr. Lonsdale-Carr:

Re: Complaint Regarding Dr. Seema Marwaha

The Inquiries, Complaints and Reports Committee (the "Committee") of the College of Physicians and Surgeons of Ontario has now considered your complaint. The Committee made its decision after a careful review of all relevant information gathered during the investigation. A copy of the Committee's written decision and reasons is enclosed.

If you believe that the Committee's investigation was inadequate, or its decision was unreasonable, you can request a review by the Health Professions Appeal and Review Board (HPARB). HPARB, a body created by the government of Ontario, is entirely independent and separate from the College.

You must make any request for a review directly to HPARB, and not to the College. Address your request to:

Health Professions Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4
Tel: 416-327-8512 Fax: 416-327-8524 E-mail: hparb@ontario.ca
HPARB website: http://www.hparb.on.ca/

If you are requesting a review, please ensure you include the College file number, the full names of the parties, the ICRC decision and its cover letter**.** Please note that your right to ask for a review expires 30 days after the date you receive this letter.

If either party appeals this decision, HPARB will contact the College to confirm your address. We will provide HPARB with the contact information that you have provided to us during the course of the investigation.

Sincerely**,**

OFFICIAL COPY

The Inquiries, Complaints and Reports Committee

/pmd
encl.

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE
(the Committee)

DECISION AND REASONS

CASE NO.:	CAS-454036-H3D6Y2 (CAS-454033-X8L4J8)
COMPLAINANT:	Anthony Lonsdale-Carr (Son)
PATIENT:	Josephine Lonsdale Heughan
RESPONDENT:	Dr. Seema Marwaha
CPSO NUMBER:	89002
SPECIALTY:	Internal Medicine

INTRODUCTION

The late Patient was admitted to St. Michael's Hospital (SMH), Toronto, on July 21, 2023 for nausea, vomiting and possible small bowel obstruction.

The Respondent cared for the Patient from July 22 to 23, 2023, when the Respondent was attending on the general internal medicine service at SMH.

The Patient passed away in the hospital on July 23, 2023, at the age of 100 years old.

The Complainant is concerned that between July 21 and 23, 2023, the Respondent was negligent in the care she provided to the Patient. Specifically, the Complainant is concerned that the Respondent:

- **Failed to inform the Complainant that a do-not-resuscitate (DNR) order had been written for the Patient, against his wishes and without his consent;**
- **Did not communicate information regarding the Patient's condition or prognosis; and**
- **Delayed ordering a CT scan to rule out a bowel obstruction until the Patient was too sick to have it done. The Patient was admitted to hospital for vomiting, abdominal distention and an x-ray identified blockage.**

At the outset, the Committee wishes to express its sincere condolences to the Complainant on the loss of his mother.

The Complainant also expressed concern about another physician. The Committee will address those concerns in a separate Decision and Reasons.

DISPOSITION

The Committee considered this matter at its meeting of April 24, 2024. For the reasons set out below, the Committee takes no action on this complaint.

ROLE OF THE COMMITTEE

When the College receives a complaint about a physician, the Committee, with the assistance of staff, conducts an investigation. Completed, written records of investigation are presented to panels of the Committee, which meet regularly to review and dispose of these.

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The Committee will, in some instances, refer a matter to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT or the Discipline Tribunal) for a live hearing into allegations of professional misconduct or incompetence. This occurs only where the Committee determines that referral to the Discipline Tribunal is in the public interest, and that the available information has a reasonable chance of supporting a successful prosecution. Finally, the Committee may refer a physician for incapacity proceedings.

The Committee cannot award or recommend financial compensation.

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The Committee appreciates the participation of the Complainant in bringing these concerns to the attention of the College. Public engagement helps the College to protect the public interest and improve the quality of physicians' care. The Committee also acknowledges the Respondent for demonstrating professional accountability in responding to this complaint.

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INFORMATION BEFORE THE COMMITTEE

The Committee considered the information obtained during investigation of this matter. In most cases, this includes information from both the Complainant and the Respondent, as well as the medical record.

The Committee is bound by legislation and regulations, which are applied in the decision-making process. The Committee also refers to the College's publication, "The Practice Guide", as well as College policies and related guidance documents which reflect the College's professional expectations of physicians practising in Ontario. These documents are available on the College's website. The Committee will provide a copy of any policy referred to in this decision.

As part of its decision-making process, the Committee always considers the physician's history with the College, if any.

ANALYSIS

The Committee considered the following points in reaching its decision:

The Respondent failed to inform the Complainant that a do-not-resuscitate (DNR) order had been written for the Patient, against the Complainant's wishes and without his consent

- In her response, the Respondent indicates that:
    - On July 22, 2023, she initially examined the Patient in the Emergency Department (ED). She was concerned that the Patient had a bowel obstruction. She ordered x-ray imaging of the Patient's abdomen. She informed the Complainant that the Patient was very unwell, and that she would not withhold any care from the Patient because of her age, but if the Patient were to become sicker, she may not be eligible or safe to receive some testing and care.
    - She consulted the Critical Care Response Team (CCRT) and ordered an urgent CT scan. She reassessed the Patient later that day and reviewed the Patient's blood work, which indicated that the Patient was in probable multiorgan failure.
    - She participated in a case conference with the CCRT physician, and they agreed that the Patient was too unstable to transfer to the CT scanner. She spoke to the Complainant and informed him that the Patient was dying and that any efforts to save her would not prolong her life and would likely cause her more suffering. She asked the Complainant if she could consult palliative care and he agreed.
- The medical records indicate that the care plan was based on the clinical presentation of the Patient, who had multiple co-morbidities and was at end-of-life. The Patient presented to the ED with nausea, vomiting, hypotension, and hypovolemia. She had a bowel obstruction and acute kidney injury. She received treatment with volume replacement, supplemental oxygen, a nasogastric tube and antibiotics. Multiple health teams assessed the Patient and unanimously felt the risk of further invasive measures, including transport to a CT scanner and surgery, would not change the outcome and could potentially prolong the Patient's suffering. It is documented that this was

communicated to the Complainant, and that he understood and agreed with this plan.

- As such, the records support that the Respondent informed the Complainant that the Patient was at end-of-life and further invasive measures would cause more harm than benefits, and the Complainant agreed. In the absence of convincing evidence to the contrary, the Committee is satisfied that the contemporaneous medical record is a reliable source of information as to what occurred.

The Respondent did not communicate information regarding the Patient's condition or prognosis

- The records satisfy the Committee that the Respondent and the Patient's healthcare team shared information regarding the Patient's condition and prognosis with the Complainant on multiple occasions. There are several documented discussions with the Complainant. There is extensive documentation that the Respondent communicated the Patient's condition, prognosis, care plan and rationale behind the care plan to the Complainant. The Committee notes that it appears that the Complainant received information regarding the Patient and was involved in the Patient's care.

The Respondent delayed ordering a CT scan to rule out a bowel obstruction until the Patient was too sick to have it done; the Patient was admitted to hospital for vomiting, abdominal distention and an x-ray identified blockage

- The Respondent indicates that she cannot comment as to whether the CT scan could have been ordered earlier given that the Patient was initially under the care of the ED team. She explained that she ordered the CT scan immediately after her first assessment of the Patient; she spoke to radiology to get the CT scan done urgently; she called CCRT to see the Patient more urgently. The scan had to be put on hold because of the Patient's clinical instability.

- The Committee notes, as previously stated, that multiple health teams, including the Respondent, assessed the Patient and unanimously felt the risk of further invasive measures, including transport to a CT scanner and surgery, would not change the outcome and could potentially prolong suffering. As such, it was reasonable for the Respondent to determine that a CT scan transport would be unsafe for the Patient.

The first 3 paragraphs of this page are the only truths spoken in these half-dozen pages of lies and obfuscations.

- Overall, the Committee is of the view that the Respondent provided reasonable and appropriate care for the Patient and will take no further action on this complaint.

Non-disclosure of Committee Members' Names

- In reviewing the investigative file, the Committee observes that the Complainant has repeatedly made inflammatory and threatening remarks towards the Respondent and hospital staff. This includes the dissemination of photographs of the Respondent on public online platforms. The Complainant informed the College that he plans to "blacken the doctors' reputations", and that the physicians "will wish they were dead".

- Furthermore, the Complainant left an exceptionally high volume of inflammatory and threatening voicemail messages for the College. The Complainant shares his intention to post the Committee's decision publicly and notes that there will be a "rude awakening" if the College takes no action.

- The Committee is concerned by the Complainant's statements and believes, in the interests of safety, that it would be reasonable in this case not to disclose the identities of individual panel members. This is an infrequent occurrence, although nothing in the Code requires that the names of panel members be disclosed. In the circumstances, the Committee believes it is reasonable for panel members to remain anonymous. This matter was considered by a panel of the Committee consisting of three physicians and one public member.

Gmail

Anthony Carr <info@anthonycarrpsychic.com>

Regarding the Death of Josephine Victoria Lonsdale (Heughan) at St. Michael's Hospital

Mr. Sanders <LBennySanders@teachers.org> Tue, Aug 6, 2024 at 12:10 PM
To: HPARB@ontario.ca
Cc: Anthony Carr <info@anthonycarrpsychic.com>

Hello to the members of The Health Professions Appeal and Review Board,

Please find the attached materials regarding the Death of Josephine Victoria Lonsdale (Heughan) at St. Michael's Hospital.

Application was made to The Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario who made a clearly unreasonable decision regarding this horrendous failure and cover-up at St. Michael's Hospital in Toronto.

I am sending the correspondence that was exchanged between concerned parties for your review.

Included is an overview which is the document outlining details of the events that lead to the orchestrated death of Ms. Lonsdale at St. Michael's Hospital. These are the details that have been presented to a Justice of the Peace at The Ontario Court of Justice as a request for Private Prosecution of the doctors at St. Michael's. The justice has asked that we exhaust all other avenues before she decides to move forward.

We are giving the HPARB the opportunity to adequately deal with this terrible situation before taking it back to the court level.

Please be aware, that it has now been just over a year since Ms. Lonsdale's death at the hands of Dr. Michael Sklar and Dr. Seema Marwaha (due to the delay in the decision of CPSO), and it is of utmost importance that this be dealt with it by your board in a timely manner. There is a Statute of Limitations and if the proceedings are to move to the court level, they must be put in place within two years of the time of the crime. We thereby trust that you will review this appeal and make your decision in a judicious manner.

Please feel free to contact me at any time either by email or telephone (416) 949-0410 as I am representing and supporting Anthony Carr (Lonsdale) in regard to this appeal. You may further contact Mr. Carr at (647) 231-2001 [mobile] or (416) 698-9901 [home] if you wish.

Lyall Sanders

2 attachments

An Overview of This Terrible Situation.pdf
50K

Important Documents Regarding the Death of Josephine Victoria Lonsdale (Heughan).pdf
6700K

Health Professions Appeal and Review Board

La Commission d'appel et de révision des professions de la santé

Ontario

In reply please quote: File # 24-CRV-0541

CONFIDENTIAL

August 12, 2024

Anthony Lonsdale-Carr — Applicant Complainant

RE: COMPLAINT REVIEW - MEDICINE
ANTHONY LONSDALE-CARR AND MICHAEL SKLAR, MD

The Health Professions Appeal and Review Board ("the Board") has received your request that it review a decision of the Inquiries, Complaints and Reports Committee/Complaints Committee of the **College of Physicians and Surgeons of Ontario.** However, your request was not received within the permitted time frame.

A request for review must be made within thirty (30) days after you receive the notice of the right to request a review from the College. Notice is presumed to have been received on the fifth day after the College issued it. Information from the College indicates that the notice was mailed to you on **May 23, 2024**.

The Board received your request for review on **August 6, 2024** being **40** days beyond this thirty-five (35) day limit.

However, the Board may extend this thirty-five (35) day limit if you provide reasonable grounds why your request was late AND it is satisfied that no person will be unduly prejudiced. The Board cannot extend the time limit by more than sixty (60) days beyond the thirty-five (35) day limit.

Please submit written comments to the Board within thirty (30) days of the date of this letter, setting out reasonable grounds on which the Board should consider extending the time limit. Except in exceptional circumstances, the Board provides copies to the parties of all written correspondence and material provided to the Board by you or by any party. All correspondence and material will also be shared with the Board's panel prior to the review. If you do not wish for certain information to be shared, do not include it in your correspondence.

The Board will consider all written comments received before making its determination.

I will notify you in writing of the Board's direction.

Yours sincerely,
Health Professions Appeal and Review Board

Ashvini Jeyanthan
Case Officer

c: College of Physicians and Surgeons of Ontario (CPSO File # CAS-454034-R7K9Q5)
Dr. Michael Sklar Respondent

Gmail

Anthony Carr <info@anthonycarrpsychic.com>

Regarding Occurence 24-1621628

L. Benny Sanders <LBennySanders@teachers.org> Wed, Oct 9, 2024 at 10:40 PM
To: 7902@tps.ca
Cc: Anthony Carr <info@anthonycarrpsychic.com>

Hello to you,

I am contacting you regarding the death of Josephine Lonsdale (Heughen).

Attached is a letter outlining the steps taken so far. We spoke with officers a couple of months ago and were direced to contact "The Health Professions Appeal and Review Board". They have stated that they will not review the case, so we are back to asking Toronto Police Services to investigate before possibly moving on to a Private Prosecution via The Ontario Court of Justice.

Further attached are some additional documents with more details. I have complete details (including over 200 pages of clinic medical reports detailing every action).

When the time comes for you to speak with Mr. Carr, I will be glad to arrange a meeting.

Please contact me at (647) 712-7283 as I am assisting him in getting justice for this terrible crime against his Mother.

Kind regards,

Lyall Sanders

3 attachments

1 Regarding the death of JOSEPHINE VICTORIA LONSDALE _HEUGHAN_ for Police Report - final.pdf
81K

2 Important Materials Regarding the Death of Josephine Victoria Lonsdale (Heughan).pdf
6306K

3 Some Notes From Anthony Carr (Heughen).pdf
45K

Lyall Sanders
2703 St. Clair Ave East - C16
East York, ON M4B-3M3

Monday October 7th, 2024

To: Toronto Police Service
40 College Street
Toronto, ON M5G 2J3

Police Occurrence Report #24-1621628

Regarding the Death of Josephine Victoria Lonsdale (*Heughan*)

"A Mother's love is like no other, It nurtures, comforts, and understands" (**Helen Steiner Rice**). **Josephine Victoria Lonsdale (*Heughan*)** was a Mother who gave her undying love to her children, **Anthony Carr (Heughan)**, born December 6th, 1943 and **Tina Higgins (née Heughan)**, born May 2nd, 1953, from their births until her tragic death on July 23rd, 2023. But her love extended well beyond her family. A decorated WWII veteran, she drove an ambulance, nursing and caring for the injured, the dying. She has cared for many thousands of individuals, at times risking her own life to save theirs. In addition, for years after the war Josephine was a nurse at Sunnybrook Hospital, spreading her love for humanity to patients there.

I personally felt that love from her and every time I spoke with Anthony on the phone, I insisted that he give her a hug and kiss from me. Her sudden death hit me much as did the passing of my own Mother, Iris Margarite Sanders Jarvis (Searle) in 1986, who died, of natural causes, much too early at the age of 57. The loss of a maternal parent is always saddening but nothing can compare to the devastation that Anthony has experienced as a result of the murder of his Mother, Josephine Victoria Lonsdale (Heughan) at St. Michael's Hospital. More than a year later, he still cries every time we pass a place that he and his Mom used to visit, or at the mention of a movie they used to watch or the many another activities they did together. Anthony's love for his Mother is reflective of the love she gave to him and everyone whose life she touched.

Anthony was her sole caregiver from the 1990's until her life was cut short by the callous decisions of Doctors **Michael Sklar** and **Seema Marhawa**.

Josephine Victoria Lonsdale (Heughan) entered hospital in relatively good health (based on EMS reports of blood pressure, pulse and vital signs - 7/21 22:25 Paramedic report BP 124/78 BPM 85 - Christopher DeSaulniers), with a problem keeping food down. It must be noted that Dr. **Marwaha** is listed as "most responsible healthcare provider" on the official Discharge Summary paperwork and it was she who cancelled an important CT scan that was necessary to properly diagnose the blockage that Josephine had experienced. Many hours later staff was still anticipating this scan because they were not told that Marwaha had erroneously withdrawn this crucial procedure.

It is important to realize that **Dr. Cole Clifford** made an entry in clinical notes stating that Josephine was at "Low risk" for readmission. At 12:55 on July 22nd, 2023, it was also entered into the notes that she did not have any trouble focusing, her thinking was not disorganized and it says in multiple reports made by the SMH team that they were able to speak to her. It was further stated that Josephine had a pulse of 83 bpm, only a moderate presence of "fluid retention' but mild nausea, vomiting and a distended abdomen.

Anthony spoke to numerous members of the St. Michael's team and said in no uncertain terms that his Mother was to be ***"resuscitated at all costs"*** (Code 20) using all available methods. Doctor Cole Clifford (Senior Resident), specifically confirmed this with Anthony "twice", just to be certain. This was common practice any and every time Josephine Lonsdale was admitted to hospital over many years.

The discharge summary states "Her son was quite clear he wanted her to have access to all care including resuscitation. As such, we arranged for an urgent non contrast CT of her abdomen". The CT Scan was

cancelled by Seema Marwaha at 3:45 on July 22nd. The staff was not informed of this and hours later were still expecting this to be done.

In the entry of 13:52, it says that Dr. Sklar (the "doctor from ICU) spoke to son, agreed DNR". In the clinical notes it states that the "Do Not Resuscitate" was ordered, by Sklar, at "06:29 - discontinue FULL CODE" signed by Jade Sullivan, nearly seven and half hours earlier.

This is absolutely against the official "Policies" written by**: The College of Physicians and Surgeons of Ontario (CPSO)** - (Approved by Council: September 2002 - Reviewed and Updated: February 2006, September 2015, May 2016, September 2019, March 2023) in the section titled ***"Decision-Making for End-of-Life Care"*** under the heading ***Withholding Resuscitative Measures***: "the physician can write an order to withhold resuscitative measures in the patient's medical record but **must**, before writing the order:

a. inform the patient and/or SDM that the order will be written;

b. communicate information regarding the patient's diagnosis and/or prognosis, and explain to the patient and/or SDM why resuscitative measures are not appropriate, including the risk of harm in providing those interventions and the likely clinical outcomes if the patient is resuscitated; and

c. provide details to the patient and/or SDM regarding clinically appropriate care or treatment(s) they propose to provide."

[To note, the acronym SDM refers to the Substitute Decision-Maker of the patient. This was Josephine's son, Anthony Heughan.] **No communication** was made to Anthony before the change was ordered.

Realizing afterwards that they had done wrong, they have tried to cover up the details of their life ending choices by making false representations of their actions. Thoroughly researched clinical medical notes (provided to Anthony by the hospital) prove their malice and indicate negligence towards their sworn duty to care for their patients, specifically **Josephine Lonsdale (Heughen)**.

The above is an extremely brief summary of the events, but a more detailed account is attached to this letter, if the information is needed for full disclosure. Further, the clinical notes (hundreds of pages in length) can be provided if need be.

I, **Lyall Sanders**, am assisting my friend and long time associate, **Anthony Carr (Heughan)** in the research and presentation of this information. We have taken **all** the necessary steps (see below) that have been requested of us. As a close friend of Anthony, and his Mother, I know he would ***never*** agree to the ***"Do Not Resuscitate"*** order made by Dr. **Sklar** and I'm absolutely positive that this is why they did not inform Anthony until it was too late.

1) Letters to patient relations (Samantha Edgar) at St. Michael's Hospital.

2) A meeting (which I attended with Mr. Heughan) with members of the SMH team, Ms. Edgar, Dr. Marhawa and Dr Sklar.

3) Letters to **The College of Physicians and Surgeons of Ontario** (CPSO). **The Inquiries Complaints and Reports Committee** of this case, filed as **CAS-454036-H3D6Y2 [CAS-454033 X8L4J8]** decided to take ***"no action on this complaint".***

After the correspondence with CPSO, we had a meeting with a Justice at **The Ontario Court of Justice** who suggested additional steps could be taken before a *"Private Prosecution"* of the Doctors be embarked on. We contacted local police and were instructed to attend Police Headquarters at 40 College St. Eventually we had a meeting with homicide officers in the lobby at 2703 St. Clair Ave East, East York.

The **Occurrence Report #24-1621628** has the details. The officer, a former hospital employee himself, informed us to continue our appropriate process by contacting the Health Professions Appeal and Review Board and to report back to the police after contacting the ***HPARB***.

4) In regard to **CAS-454034-R7K9Q5 24-CRV-0541, The Health Professions Appeal and Review Board** has stated that "the Board shall not review the decision of the panel of the Committee".

We now bring this process back to Toronto Police Service to pursue justice, and we ask that, after review by the investigating officer(s), charges be brought against Doctor **Michael Sklar** and Doctor **Seema Marhawa** who are directly responsible for the death of **JOSEPHINE VICTORIA LONSDALE (HEUGHAN). W**e ask that they be charged with the crime of ***"homicide with malice aforethought"***.

As mentioned, we have much more evidence to support this case, and which we will gladly provide for your investigation. We further have in our possession the clinical notes and various letters and email messages that have been exchanged between the interested parties.

Doctors **Seema Marwaha** and **Michael Sklar** collaborated to **kill Josephine Victoria Lonsdale (Heughan)** . Marwaha cancelled an investigative medical procedure meant to save Josephine's life, whilst Sklar illegally decided to not resuscitate his patient and then they attempted to cover up their crimes. This is a teaching hospital, and young healthcare professionals are learning these despicable practices!

"Doctor Michael Sklar and Doctor Seema Marwaha must be made accountable for the death of **Josephine Victoria Lonsdale (Heughan)** and charged with her murder. This may in some way bring an inkling of justice to her unjust treatment and will certainly protect future patients of St. Michael's Hospital from suffering similar fates at the hands of Dr, Michael Sklar, Dr. Seema Marwaha and any others who have learned their detestable methods".

You may contact me whenever necessary at (647) 712-7283 or by email at LbennySanders@teachers.org *and to* info@AnthonyCarrPsychic.com

We await your anticipated reply.

Lyall Frederick Gordon Sanders

" A gift from above, so precious and rare,
A Mother 's love, beyond compare." **Author Unknown**

The bitterest graveside tears ever shed, surely must be by those who never said: "I love you, Mom"

Sir Anthony Lonsdale-Carr (aka Anthony Heughan)

To My Mother

by Edgar Allan Poe

To my Mother , so gentle and kind,
Whose love is a treasure I'll always find.
Through darkest nights and brightest days,
Her unwavering support lights my way

Edgar Allan Poe, 'To My Mother'.

Because I feel that, in the Heavens above,
The angels, whispering to one another,
Can find, among their burning terms of love,
None so devotional as that of 'Mother' …

The Gift of a Mother

by Unknown

A gift from above, so precious and rare,
A Mother 's love, beyond compare.
She showers us with blessings each day,
Guiding us along life's winding way

Here is the Police Occurrence Report #24-1621628

July 16, 2024

To Whom It May Concern,

I've known Anthony Carr (aka Anthony Heughan) and his mother Josephine Lonsdale (Heughan) for more than 40 years. She was a veteran of the Second World War and Tony a loyal and dedicated son. Tony looked after his Mother's every need, especially as she aged. Most siblings would have put their parent in a special-care home but Tony would have none of that. He loved his Mom so much and developed and enjoyed a special bond and if it were up to him he would have kept her alive forever.... I know Anthony would *never*, ever agree to change a full code (to resuscitate at all costs!) to a DNR (Do Not Resuscitate) under any circumstances! She was a very special person and Tony a special son....

Les Pyette,
Former CEO Toronto Sun and National Post.

September 08, 2024

To Whom It May Concern,

My name is Justin Da Silva and I've known Anthony Heughan (aka Anthony Carr) for 20 years. What started out as a part-time job typing up his manuscripts and helping him develop an online presence, has turned into a very close friendship. Some might see it as being a bit odd, considering there is a two-generation gap between our ages (43 years), but we found that our senses of humor have always lined-up well which gave way to lots of laughs over these two decades. It is an interesting mix of two worlds, with our relationship touching on personal as well as business. I am not kidding when I say that we have heard each other's voice practically every day for the past 20 years…. I mention all this to paint the picture that we are both very much integrated in each other's life. He knows everything that goes on in my life, including the lives of my family members. And the same goes for me, I know pretty much everything that goes on in his life and with the lives of his family members. For that reason, I want to talk about the relationship Anthony had with his Mother, Josephine:

I had the privilege of meeting and getting to know Anthony's WWII veteran Mother – a battle front-line nurse – on many occasions over the years; whether it was at their house, or at the end of my driveway where they would make one final stop (sometimes with a Dairy Queen ice cream in their hands) after a long weekend drive around the city, reminiscing about all their shared memories. In my eyes, Anthony is the son any Mother would hope to have when they reach their golden years. What could be better than having a dedicated son to take you out on the town every week, be a sole care-giver – not only to keep you healthy and clean, but also to encourage you to stay active and young. Some older people are forced into old-age homes because their adult kids don't want to make time for them. Anthony always refused this idea because he knew that no one would be able to match the love and care he was able and willing to give his Mother. My witness of this over the years is only one of the many lessons I have learned from Anthony; but I would say *it is the greatest lesson that I will take with me,* as I grow older and someday will have to watch my own Mother grow old and feeble and unable to care for herself. The greatest respect I have developed for Anthony is from watching him take care of his Mother in a way that I feel Hollywood truly missed out on. Because a movie that could capture them – unknowingly – on one of their Sunday drives together would be something lovely to see. Anthony once forgot to turn off his phone after a conversation with me and I had the pleasure of listening to them reminisce about the old days. I decided to listen in because it was really something sweet to listen to this 80-year-old man chaperoning his 100-year-old Mother around town and talking with so much enthusiasm as he pointed out old city landmarks and just *wanting to make every single moment count*….

With all this said, and knowing Anthony as well as I do, I can say without any doubt whatsoever that there is *no way* he would *ever* have agreed to change a Full Code (Resuscitate Using Every Method Available) to a DNR (Do Not Resuscitate). Where any other person in Anthony's position might see his or her 100-year-old mother as being nothing more than a nuisance to have to keep her around at this point, Anthony would gladly have taken care of his Mother for another 3, 4, 5 – even 10 years – had he been given the opportunity. I really hope I can be even *half* the son that Anthony has been, when my Mother reaches old-age.

Respectfully,

Justin Da Silva,
Anthony's typist, web developer, email checker, et al (just to name a few).

2024-Jul-07

Dr. Leonard Kuwahara
16 - 1450 O'Connor Drive, Toronto, ON, M4B 2T8
Tel: (416) 694-1171 Fax: (416) 694-7885

Anthony Heughan
7881 304 492XL DOB: 1943-Dec-06
11 Sutherland Avenue, Toronto, ON,

To Whom It May Concern,

I have known Anthony Heughan for over thirty five years, as well as his late mother, Josephine Heughan.
Anthony was devoted to his mother and they were in an excellent relationship. It is of my opinion that it is unlikely that he would sign a Do Not Resusitate order for his mother.

Sincerely,

Leonard Kuwahara MD