June 15, 2012.

Dr. Anny Sauvageau,
Chief Medical Examiner
4070 Bowness Road N.W.
Calgary Alberta T3B 3R7

Re: Request for Fatality Board Review and Recommendation for Judical Fatality Inquiry

Dear Dr. Sauvageau,

On the morning of May 19, 2012 Greg Price, our 31 year old son, died of a treatable disorder (pulmonary embolism) three days after undergoing surgery to remove a cancerous testicle and fifteen hours after attending a Calgary Emergency Department. Despite the fact he had known about the obvious risk factors (for metastatic cancer - to the abdominal lymph nodes), and had experienced and discussed the cancer symptoms, the risk of deep vein thrombosis was not discussed nor appropriate investigations initiated and therefore he was deprived of life saving treatment.

Greg should have been operated on and undergoing chemotherapy treatment many months before he died. The history of how he was handled and treated is much more than just the last missed diagnosis. It is also one of unbelievable and unforgiveable delays in accessing the appropriate care that could have saved his life. Greg was a victim of a primary care system that does not (or cannot) transfer the care of urgent patients to specialist care in an effective and timely way. The result was when treatment was initiated it was long past the time to achieve the optimal outcome and which increased the risk of life threatening complications from the underlying disease and treatment.

Thirteen weeks elapsed from the time Greg was first referred to a specialist in order to diagnose his rapidly growing testicular cancer until that specialist made an appointment available to Greg. Greg needed an advocate in the primary care system to speak up and reduce this waiting time from weeks to days, but there wasn't one. Greg needed a specialist care system that would not let patients with an urgent need for care to drop through the cracks but there isn't one. These large gaps in the system meant his surgery was delayed to the point where the risk of post operative thrombosis increased substantially. This was not a complication that was ever discussed with Greg and which denied him and it also denied his family the opportunity to participate in his care and advocate for the tests and the treatment he needed in a timely fashion in order to survive.

We understand because Greg's death occurred within 10 days of an operative procedure, that alone should qualify for the Fatality Review Board Review and the recommendation for a Judge led, Fatality Inquiry. In addition, we believe that there is so much more to Greg's tragic journey extending back over many months of gaps in care. These events and the gaps in care need to be fully and publically investigated as well.

We have attached a description of what we now know as Parents and as Siblings about how Greg was handled over the last number of months. We have also included our view of the state of patient care in Alberta, given Greg's journey and our own personal experiences.

We have posed our own questions about the three different phases of Greg's journey through the local and community level, to the Alberta Health System and the Urology Centre, the surgery itself and then finally to the Emergency Department.

We firmly believe that in order for critical changes and improvements to be made to patient care in Alberta, there needs to be an independent, third party and powerful investigation done of all aspects of Greg's journey. We believe that a Judge led Fatality Inquiry into Greg's search for diagnosis and treatment would have the best chance of causing these changes to happen. Changes that can and will save lives.

We respectfully request that you request that the Fatality Review Board review Greg's case and recommend to the Minister of Justice, that a Judge led Fatality Inquiry be undertaken as quickly as possible.

Dave Price, Father, Isabelle Price, Mother Matt Price, Brother Cathy Price, Sister in law.

Teri Price, Sister Joanna Price, Sister Chad Price, Brother