CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts Building

in the City (City, Town or Village) of Edmonton (Name of City, Town, Village)

on the 20th day of January, 2005 (year) (and by adjournment

on the ______ day of ______, ______ (year),)

before the Honourable Assistant Chief Judge A.H. Lefever, a Provincial Court Judge.

A jury was [ ] was not [X] summoned and an inquiry was held into the death

of John Dach (Name in Full) 66 (Age)

of Jubilee Lodge Nursing Home, 10333 - 76th Street, Edmonton, Alberta, (Residence) and the following findings were made:

Date and Time of Death: October 2, 2003 at 9:10 a.m.

Place: Jubilee Lodge Nursing Home, 10333 – 76th Street, Edmonton, Alberta

Medical Cause of Death: ("cause of death" means the medical cause of death according to the International Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquires Act, Section 1(d)).

Atherosclerotic coronary artery disease

Manner of Death: ("manner of death" means the mode or method of death whether natural, homicidal, accidental or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Natural

Circumstances under which Death occurred:

John Dach was a resident at the Jubilee Lodge Nursing Home for a period of almost 6 months (09April03 to 02October03) until his death on October 2. During his residency, he suffered from a number of conditions or illnesses, including blindness, high blood pressure, coronary heart disease, and diabetes. He required assistance in eating, although he was capable of performing some tasks without any assistance.

The circumstances of his death described in the evidence are as follows. On October 2, Dach was having breakfast while seated at a table referred to as the feeding table with 4 other residents. Seated at this table was Dorota Szymanowka ("Szymanowka"), who had been employed at the Jubilee Lodge Nursing Home for 4 years and 2 months, whose job at that time and place was to help the five residents eat breakfast. At this time Dach was eating toast. At or about 09:00 Beatriz Cabrillas ("Cabrillas"), who had been employed at the Jubilee Lodge Nursing Home for 3 and ½ years on October 2, returned from her half-hour break and replaced Szymanowka at the feeding table. After a brief conversation between Szymanowka and Cabrillas, Szymanowka left to take a scheduled work break.

I am satisfied that Szymanowka remained at the feeding table until Cabrillas arrived, and that when Cabrillas arrived, Szymanowka would have said words to the effect of what had occurred to that point at the feeding table. The evidence I heard suggests to that point nothing untoward or out of the ordinary had occurred concerning Dach.

Cabrillas began working with the patient on her immediate left. At this time working from left to right, Dach would have been the 4th resident that Cabrillas reached. When Cabrillas looked at Dach, he was slumped over and appeared to have ceased breathing. Cabrillas called out to Dach, and when no response was received, immediately called out for additional staff assistance.

Fearmi Pfleider ("Pfleider") a Registered Nurse who had been employed at the Jubilee Lodge Nursing Home for approximately 17 years and who just happened to be close at hand immediately responded. Cabrillas and Pfleider both noted that Dach's lips appeared blue, signaling to them that he had stopped breathing and that his body had ceased to deliver the proper supply of oxygen. While Dach had made no noises nor gestures which appeared consistent with a blocked airway, Cabrillas and Pfleider proceeded on the basis that his airway was blocked.

Although precise times were not kept due to the nature of what was occurring, I am satisfied that within less than a minute, Pfleider and Cabrillas administered emergency treatment to Dach including the Heimlich maneuver, chest thrusts and head thrusts, all designed to assist someone whose airway was obstructed. During these efforts, a small piece of moist toast about the size of Pfleider's thumb was forced out of Dach's mouth shortly before 09:00. However, when the efforts did not appear to have reestablished Dach's airway, Pfleider called out for more help, which resulted in Nancy Vreugde ("Vreugde"), a Registered Nurse who had been employed at the Jubilee Lodge Nursing Home for 11 years and who was working in another area of the same floor, immediately responded. Both Pfleider and Vreugde continued to administer emergency treatment to Dach consistent with establishing an airway.

During these efforts, Donna Domenichelli ("Domenichelli)", who was employed by Jubilee Lodge Nursing Home but who had no hands-on care duties with residents, came by and observed what was happening. Domenichelli instructed Pfleider and Vreugde to move Dach from the feeding table to another location in the dining area, and when it appeared that Dach had begun to breath and was taking spontaneous breaths, all of Cabrillas, Pfleider, Vreugde, and Domenichelli assisted in moving Dach to his room on the second floor.

Pfleider and Vreugde both noted a gasping breath and then some spontaneous respiration by Dach. Domenichelli noticed the single gasping breath. Upon arriving at Dach's room, vital signs were taken. Pfleider was sent to the nursing station to check Dach's Personal Directive and to call Dr. Tilley. Speaking with Dr. Tilley, Pfleider indicated that it appeared Dach had choked but was now breathing, and asked whether an ambulance should be called and Dach transferred to an acute care hospital. Dr. Tilley indicated that Pfleider should call the family first to determine their instructions. The stated explanation for this was that sometimes the Doctor would instruct staff to call the family to determine if the family wanted the resident taken to hospital. I was also told that sometimes when an ambulance had attended, EMS personnel would have to call around to see which hospital would accept the patient.

While this telephone call was in progress, Vreugde came to the nursing station to advise Pfleider that Dach had died. This information was communicated to Dr. Tilley, who undertook to come to the Jubilee Lodge Nursing Home later that morning to sign the necessary papers.

It is helpful to set forth the relevant terms of Dach's Personal Directive at this point. This Personal Directive had been signed on April 11 by Doug Dach, son of Dach as Dach's legal representative when Dach first became a resident at the Jubilee Lodge Nursing Home. This Personal Directive stated in part:

"If I [John Dach] become seriously ill and my life is in danger, I request that I be treated as indicated below:

1. Transfer to Acute Care Hospital without Cardiopulmonary Resuscitation

If a **serious deterioration** occurs, a transfer to an acute care hospital **would be requested**. Assessment would be made in the acute care hospital emergency department and a decision made there whether to admit or return to Jubilee Lodge Nursing Home. No cardiopulmonary resuscitation and no admission to an intensive care unit." (my emphasis)

I was not clear what was to happen in respect of Dach's Personal Directive. With respect, there appeared to be some confusion. Both Dr. Tilley and Dr. Dowling agreed that the event involving Dach was a "serious deterioration". Was it that the words "would be requested" meant that staff would call around to see which hospital would accept a man who appeared to their eyes to have had a choking incident to see if the emergency department would accept that patient, and then call the ambulance. Based upon the view taken by staff that Dach had regained spontaneous use of his airway, this

interpretation would be reasonable. It was explained to me that within this context, in the past there had been problems encountered in getting patients admitted to an acute hospital and that on occasion calls had to be made to find out where there was a vacancy. Similarly, Dr. Tilley's advice, given initially within this context would also be reasonable. This view and advice would be predicated upon the understanding that, while there had been a serious deterioration, it appeared that the event triggering the serious deterioration had been favourably resolved.

It is equally possible that one might interpret the evidence to suggest that, regardless of having a Personal Directive which spelt out the resident's wishes in the event of a medical emergency, the choice expressed in the Personal Directive was only to be acted upon if the treating physician or family was first called to find out if the choice in the Personal Directive was what was really intended.

In hindsight however in light of Dr. Dowling's evidence, to which I will now refer, this approach was not responsive to the precise medical event affecting Dach. Because the death was not reported to the Medical Examiner's Office, no decision was made at the time whether an autopsy would or would not be performed. This led to concerns later in respect of Dr. Dowling's opinion of the cause of death.

Dr. Dowling's report, entered as Exhibit 4, details a Medical Examiner's investigation and distinguished that investigation from an autopsy performed by a Medical Examiner. This difference arose from the following. There was no requirement to report Dach's death to the Medical Examiner. As a result, the death was not reported and the Medical Examiner was not in a position to determine immediately following the death whether an autopsy would or would not be conducted. Dr. Dowling was restricted to reviewing certain material, the most relevant of which were statements from the Jubilee Lodge Nursing Home staff, Dr. Tilley's chart in respect of his treatment of Dach, and the notes kept at the Jubilee Lodge Nursing Home in respect of care given to Dach. Based upon this review, Dr. Dowling concluded that the cause of death was natural and due to " 'cardiac arrest' arising from atherosclerotic coronary artery disease".

Upon attending at the Jubilee Lodge Nursing Home, Dr. Tilley spoke to staff and completed the "Attending Physician's Medical Certificate of Death" in which Dr. Tilley stated as the immediate cause of death "Aspiration Pneumonia". Dr. Tilley did not have the benefit of seeing the event when Dach died, and was compelled to rely upon information given to him by Jubilee Lodge Nursing Home staff. I am satisfied that they reported what they had observed, of their initial belief that Dach had choked on something, that his airway had become obstructed, that he had resumed spontaneous respiration, but that he died shortly thereafter. The expulsion of the small piece of toast would have strengthened the staff's initial thoughts, which would have been communicated to Dr. Tilley.

However, after reviewing Exhibit 4 and listening to Dr. Dowling's evidence, Dr. Tilley agreed with Dr. Dowling's opinion and accepted that his entry on Exhibit 4 was incorrect. Dr. Tilley accepted Dr. Dowling's opinion on the cause of death.

In my opinion, the cause of death was " 'cardiac arrest' arising from atherosclerotic coronary artery disease."

At the time had staff understood the precise medical event then occurring, the appropriate course of conduct would have been to instruct someone to immediately summon an ambulance while others were performing emergency measures to reestablish Dach's airway and cardiovascular circulation. However, in light of all the evidence, I am not satisfied that the circumstances of this event should have caused staff to assume Dach was suffering a coronary event and act accordingly. To conclude that an airway has become obstructed when an elderly person who, while eating breakfast appears to demonstrate lack of oxygen as evidenced by bluish lips and no visible signs of respiration, appears to me to be a reasonable conclusion to reach.

However, I am not satisfied that summoning an ambulance at the onset of the medical event would have in any way materially affected the outcome in this situation. When one looks back with hindsight, it is clear that the initial perception of staff although entirely reasonable was in error, and that calling an ambulance would have been appropriate, given Dach's Personal Directive and the fact that there was more than one explanation for Dach's medical event. Those with Emergency Medical Services training would be better equipped to deal with the event and determine if it was in fact an airway blockage, as staff here suspected, or a cardiac arrest arising from atherosclerotic coronary artery disease.

As a matter of clarification, Dr. Tilley accepted that the notation of "MIN–4 HRS" in reference to the "Approximate interval between onset and death" was in error. He accepted the timelines as detailed by the staff from approximately 09:00 to 09:10.

A Fatality Inquiry does not find fault in respect of any of the individuals who are connected to the death of a person for which death a Fatality Inquiry is being held. With respect to the notations "aspiration-pneumonia" and "MIN-4 HRS", it is clear that in completing the Physician's Medical Certificate of Death, Tilley did nothing which caused or contributed to Dach's death.

One of the purposes of a Fatality Inquiry is to answer concerns of the deceased's family, to in effect bring closure for them on such an event. I accept that Tilley's initial Physician's Medical Certificate of Death could have done that. For reasons not explained in evidence, this closure did not remain, and a review was ordered by the Fatality Inquiries Board.

Residents in nursing homes are in the main elderly, dependent, suffer from a variety of illnesses or medical conditions, suffer loss of sight, hearing and mobility, and are generally dependent upon the institutional caregivers. In society today, family members cannot always be present when a resident experiences a medical event. Where that event ends in death and where there is more than one possible cause of that death, the absence of a requirement to report the death to the Medical Examiner's Office may contribute to a family's sense of loss, unease over the death, and exacerbate unanswered or unanswerable questions in respect of the cause of death and whether anything might have been done to prevent the death of a loved one. Imposing an obligation to report the death immediately to the Medical Examiner's Office would enable the Medical Examiner to determine whether an autopsy would be ordered. While I would not expect such an obligation to trigger an avalanche of autopsy procedures, it would provide one further check-off to insure that the death in question was natural rather than from some other cause.

Recommendations for the prevention of similar deaths:

I make the following recommendations in respect of this Fatality Inquiry.

Where as here, nursing home staff who are not emergency medical personnel are faced with a medical event involving a resident which can have more than one cause, either of which is very serious, time consumed when staff attempt to deal with the event before summoning emergency medical help for the resident can contribute to the resident's death. Staff internal assistance should be provided concurrently with summoning EMS personnel and an ambulance.

1. The Province of Alberta should require all Nursing Homes licensed in Alberta to develop and adopt a policy requiring staff to call for an ambulance on an emergency basis when one of the residents experiences a medical event amounting to a "serious deterioration" in respect of the resident's health. Where possible staff should not wait until the event has either resolved itself or become more serious before so acting.

One of the purposes of a Fatality Inquiry is to provide closure for surviving family members. Achieving that purpose can be significantly affected where a family member dies in a nursing home where the cause of death is not the result of ongoing treatment of a known illness or condition. Determining the cause of death in such circumstances becomes largely anecdotal rather than based upon medical science. Performance of an autopsy when so directed by the Medical Examiner would further the purpose of family closure. The first step in this process would require nursing homes to report deaths of all residents to the Medical Examiner's Office.

2. The applicable statutory and regulatory framework should be amended to require Nursing Homes to immediately report all deaths of residents when such deaths occur in the Nursing Home to the Medical Examiner's Office for determination whether an autopsy will be performed.

The purpose of a Personal Directive is to provide clear, concise and direct instructions for care-givers in respect of how to respond to a medical event. This is even more important when the person who has given the Personal Directive is a dependent resident of a nursing home. In the case of Dach's Personal Directive, the language is capable of more than one interpretation. In this case, the Personal Directive read in part, "If a **serious deterioration** occurs, a transfer to an acute care hospital **would be requested**." Based upon the evidence that I heard, Jubilee Lodge Nursing Home staff were under the impression that where there was a serious deterioration, staff had to call local hospitals to find a hospital which would accept the resident.

This makes perfect sense if one is dealing with health deterioration which develops over a time span that allows some time for consultation. For example, if an elderly resident developed pneumonia which was not responding to antibiotic treatment, one might well envisage consultation between nursing home staff, the treating doctor and the family in which a decision would be made either to continue treating the resident within the nursing home or to transfer the resident to an acute care hospital.

However, sudden and more immediate catastrophic medical events occur unexpectedly, without warning, and marked by rapidity of onset in which there will be no time for such consultation. These events I refer to as events of "sudden deterioration". It appears to me that choice number 3 of the Jubilee Lodge Nursing Home Personal Directive does not address the possibility of sudden deterioration with any degree of clarity. Those who sign a Personal Directive should direct their attention to the possibility of sudden deterioration separate and apart from events of serious deterioration.

It is unnecessary and at this point appears unhelpful for Nursing Homes to develop a Personal Directive which would list all of the medical events that could be sheltered under this definition of sudden deterioration. Were such a document to

be prepared, it would be completely unreasonable to expect Nursing Home staff to diagnose such specific events. However, I do believe that Nursing Home staff training is sufficient to allow staff to differentiate between a serious deterioration and a sudden deterioration, and to act accordingly. In my opinion, the Jubilee Lodge Nursing Home Personal Directive does not adequately differentiate between the two possibilities, and should be amended such that a resident and family when completing a Personal Directive will turn their respective minds to the two possibilities and make an informed decision as to both. As I have already noted, from the evidence that I heard, even had Dach's Personal Directive contained such a differentiation and had EMS personnel been summoned at the onset of the incident, I am satisfied on the evidence I heard that the outcome would not have been any different.

3. The Jubilee Lodge Nursing Home Personal Directive should be amended to include an instruction of resident choice for medical treatment in the event of a sudden deterioration as a choice separate and apart from "serious deterioration".

DATED March 10, 2005,

at Edmonton, Alberta.

The Honourable Assistant Chief Judge A.H. Lefever
A Judge of the Provincial Court of Alberta