ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Courthouse

in the Town (City, Town or Village) of St. Paul (Name of City, Town, Village), in the Province of Alberta,

on the 30th and 31st days of January, 2018 (year), (and by adjournment

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

before Rosanna M. Saccomani, a Provincial Court Judge,

into the death of Cassandra Marie-Ange LAVOIE (Name in Full) 18 (Age)

of St. Paul, Alberta (Residence) and the following findings were made:

Date and Time of Death: May 26, 2013 (04:30 - 07:54)

Place: St. Paul, Alberta

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical 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 – *Fatality Inquiries Act*, Section 1(d)).

Aspiration of stomach contents consequent to severe global developmental delay of unknown etiology.

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

Natural

Circumstances under which Death occurred:

INTRODUCTION

[1] Cassandra Marie-Ange Lavoie ("Cassandra") passed away on Sunday, May 26th, 2013 following a brief stay in a residential facility operated by St. Paul Abilities Network ("SPAN") in St. Paul, Alberta.

[2] Cassandra was 18 years of age at the time of death. As a severely disabled person, she had been in the full time care of her devoted and loving parents, Richard and Joanne Lavoie, since birth. Cassandra's visit to the SPAN facility was to provide family respite and to assess suitability for long-term placement.

[3] SPAN, a support network for vulnerable persons with disabilities, offers numerous community services including various residential care options in St Paul. SPAN is managed and funded under the auspices of Persons with Developmental Disabilities ("PDD"), a program of the Alberta Ministry of Human Services.

[4] In a letter dated September 26th, 2013 to the Fatality Review Board, Mr. and Mrs. Lavoie expressed concerns about quality of staff training and care received by Cassandra in the hours before her death. As grieving parents, they were searching for information that might bring closure and peace.

[5] Upon review of their request as "Interested Parties" and the Medical Examiner's Case file pursuant to section 33 of the *Fatality Inquires Act, RSA 2000 Chapter F-9 ("the Fatality Inquiries Act")*, the Fatality Review Board supported an Inquiry on the basis that possible recommendations could prevent similar deaths.

[6] The Deputy Attorney General issued an "Order to a Judge for a Public Fatality Inquiry" on October 21, 2014. Carriage of the Inquiry was assigned May 22, 2015.

[7] The *Fatality Inquiries Act* establishes the parameters and scope of the inquiry. Any person determined to have a direct and substantial interest in the inquiry subject matter may appear to present evidence and submissions at a formal hearing. A record of the viva voce and documentary evidence heard and collected is to be preserved. At the conclusion of the hearing, the judge must submit a written report addressing certain factual findings to the responsible Minister. These include the deceased's identity, the date, time and place of death, and the circumstances, cause and manner of death. Recommendations to prevent deaths in similar circumstances may also be made. Findings of legal responsibility or conclusions of law, however, are not permissible.

Sections 49 to 53, Fatality Inquires Act.

PRE-INQUIRY CONFERENCES

[8] Pre-Inquiry Conferences were held in person and via telephone January 11th, 2016, March 7th, 2016, December 13th, 2016 and January 11th, 2017.

[9] Various issues were canvased in these meetings including the production of medical and other third party records, list of potential witnesses (ordinary and expert), general procedure, disclosure delays and other relevant matters.

[10] Mr. and Mrs. Lavoie contributed to these discussions.

[11] This Inquiry acknowledges their meaningful participation and the important contribution of all witnesses who testified.

[12] Appreciation is also extended to Mr. Brian Kash (Inquiry Counsel), and to Mr. Donald Dear, Q.C. and Mr. Ryan Martin (Counsel for SPAN) for their able and thoughtful assistance.

THE INQUIRY

[13] The Inquiry (scheduled March 7th to 8th, 2016 and June 5th to 8th, 2017) was adjourned by consent for production of third party disclosure and to accommodate the availability of material witnesses.

[14] The Inquiry proceeded January 30 and 31st, 2018 and heard from the following individuals:

1. Mrs. Joanne Lavoie (Cassandra's Mother);
2. Dr. Bernard Bannach (Assistant Chief Medical Examiner);
3. Dr. Francis Adebayo (Attending Emergency Physician, St Paul/St. Therese Health Centre);
4. Mr. Mark Robinson (Primary Emergency Medical Technician);
5. Mr. Tim Bear (SPAN Executive Director);
6. Ms. Suzanne Audette (SPAN Staff Member); and
7. Ms. Emelyn Colina (SPAN Staff Member).

[15] Documentary records and reports in evidence by consent were received from the following:

1. Office of the Medical Examiner;
2. St. Therese and St. Paul Health Centre ;
3. Dr. Francis Adebayo;
4. Family Support for Children with Disabilities Program ("FSCD");
5. RCMP ;
6. SPAN;
7. Alberta Health Services; and
8. Third Parties.

BACKGROUND

[16] Cassandra was born January 27th, 1995 in Grande Prairie, Alberta and died May 26th, 2013 in St. Paul. In early infancy, she was diagnosed with severe global developmental delay ("GDD") with unknown etiology. Dr. Bannach explained that GDD is a general clinical description for children whose cognitive and physical functioning from birth to adulthood is profoundly limited. Cassandra's gross and fine motor, verbal, social and cognitive skills were comparable to a six-month old baby. As such, she was entirely dependent on caregivers throughout her life for all basic human needs.

[17] Despite these challenges, Cassandra was a great blessing to her family and brought them purpose, meaning and joy. She was deeply cherished by her parents, Joanna and Richard, and her brothers, Dillon and Adrian, who worked together to care, nurture and protect her.

[18] The responsibility of full time care of a disabled family member is a highly demanding and exhausting undertaking. The records confirm that Mr. and Mrs. Lavoie came to accept this difficult reality and to explore an appropriate long-term living arrangement for their daughter.

[19] SPAN was founded in 1964 by a group of volunteers dedicated to improving support systems for disabled children and their families. Since then, over fifty programs and services have been established with the support of government funding. SPAN also owns and manages eighteen private residences in the St Paul community. Admission criteria to each facility varies on the basis of the applicant's age, disability and the nature of care and supervision required. Assessment and funding of SPAN's clients is the domain of PDD under Alberta Human Services.

[20] There is a waiting list for admission to SPAN residential facilities.

[21] An application dated January 19th, 2012 was submitted to SPAN by Mr. and Mrs. Lavoie on their daughter's behalf. They confirm that Cassandra, although severely disabled and wholly dependent, did not suffer health problems of significant concern. Medication and specialized treatment would not be required. (Exhibit 1, Tab 35)

[22] A SPAN medical form completed and dated February 17, 2012 by Dr. J.C. Duvenage, family physician, appears to confirm this information. (Exhibit 1, Tab 36)

[23] On May 2nd, 2013, Cassandra was examined by Dr. A. Baburam, orthopedic surgeon, for assessment of severe lower limb contractures (causing marked flexion deformities of the knees and adduction of the hips). Dr. Baburam concluded that Cassandra was a suitable candidate for a surgical procedure to release leg tension and promote weight bearing. The standard risks were reviewed with Mr. and Mrs. Lavoie and surgery scheduled at the end of May. (Exhibit 1, Tab 91)

CIRCUMSTANCES OF DEATH

A. Evidence

Residence 12 – Staffing, Training and Care

[24] Residence 12 (5214-48th Street, St. Paul) is a 3,000 square foot bungalow style facility which was opened by SPAN in 2012 for special needs adults. Mrs. Lavoie described it as "bright and beautiful".

[25] Cassandra was introduced to the staff of Residence 12 on the afternoon of May 23rd, 2013. The visit was successful and arrangements followed for an overnight stay a few days later.

[26] Mr. and Mrs. Lavoie were hopeful that Residence 12 would be a suitable placement for Cassandra's long-term care. The trial overnight stay would also afford them some respite on the weekend of their wedding anniversary.

[27] On May 25th, 2013, early morning, Mr. and Mrs. Lavoie arrived at Residence 12 with Cassandra. They provided staff with her food, diapers, television and other supplies. Mrs. Lavoie also left a handwritten note regarding diaper changes, bottle feedings, sleeping aides and positions, and soothing techniques during Cassandra's occasional "screaming" episodes. Staff members were encouraged to contact them via cell with any questions. Mrs. Lavoie briefly returned late afternoon to ensure that all was well.

[28] Although Residence 12 provides 24-hour care, it is not a medical centre. The nature of overnight care aligns with the PDD needs assessment and funding coverage approved for each

client on an individualized basis. Overnight care shifts (when clients sleep) may include: a) "sleep shifts" (support staff sleep); b) "rest shifts" (support staff may rest); and c) "awake shifts" (support staff are awake and active).

[29] According to the SPAN schedule, staff on duty on May 25th – 26th , 2013 are as follows:

Emelyn Colina: May 25 [07:00 to 19:00] May 26 [07:00 to 19:00];

Sherwin Esma: May 25 [07:00 to19:00] May 26 [off];

Atlas Bjorn-Borja: May 25 [07:00 to 23:00] May 26 [07:00 to 21:00];

Suzanne Audette: May 25 [19:00 to 07:00/S] May 26 [19:00 to 08:00];

Victor Sicat: May 25 [off]; May 26 [08:00 to 21:00].

[30] SPAN also produced Cassandra's "Daily Log" for May 25th, 2013 in which two handwritten entries appear.

[31] The first entry, initialized by Emelyn Colina, references the client's time of arrival and the general care provided (ie) "Cassie was wheeled" about the residence and "snuggled" when upset.

[32] The second entry is initialized by Suzanne Audette. This entry indicates that: Cassie was in bed at 9:00 pm; that she woke up crying at 4:00 am; that her diaper was changed; that she was given a bottle; and that she was quiet for the rest of the night.

[33] There are no other entries or log notes regarding Cassandra's stay.

[34] Ms. Colina told the Inquiry she was on shift May 26th, 2013 (07:00) as scheduled. While making morning rounds, she stood outside Cassandra's bedroom door at 07:30 and listened. She did not hear any sound and assumed Cassandra was still asleep. Ms. Colina confirmed she did not personally observe Cassandra sleeping at 07:30 as she did not enter her room.

[35] Ms. Colina did enter Cassandra's room at approximately 07:45:00 and observed vomitus. She checked Cassandra's breathing and pulse. There were no signs of life.

[36] Ms. Colina called out to Mr. Atlas Bjorn C-Borja, the other front line worker on shift, who telephoned 911. CPR was commenced on the bed.

[37] Ms. Colina told the Inquiry that while CPR should be performed on a hard surface, a backboard was not available.

[38] Mr. Born-Borja provided a handwritten statement to police confirming he called 911 immediately after Cassandra was found unresponsive "at 7:30 a.m." (Exhibit 1, Tab 21)

[39] Mr. Born-Borja's time line does not accord with Ms. Colina's statement or other evidence presented. (Exhibit 1, Tab 9)

Emergency Medical Services

[40] EMS records indicate that emergency dispatch received a 911 call regarding "an 18 year old female in cardiac arrest" at 07:54:29 May 26th, 2013. (Exhibit 1, Tab 9)

[41] Two emergency crews (St. Paul 1B1 and St. Paul 4B2) responded.

[42] St. Paul 1B1 (EMT Mark Robinson, EMT Erick Clark and EMT Tessa Kashuba) arrived on scene first and attended to the patient at 07:59:00.

[43] In an undated typed statement, Mark Robinson, the primary care EMT, describes his observations upon arrival as follows:

> " [there was]..... a very blue (cyanotic) patient..curled into a ball.....(she) was very thin and emaciated .....CPR was indeed in progress but remotely ineffective because the patient was on her mattress. My partner and I transferred her to the floor to get better CPR. Vomit (emesis) was in the patient's airway which was suctioned out by the secondary crew who responded with us. Two attempts at an IV were made on scene as well as two courses of shock analysis.....transport to the ambulance was done via spinal board. En route to the hospital a final iv attempt was made and successful.....a fluid bolus was initiated until transfer of care took place approximately one minute after.
>
> The patient's condition never changed. She was pulseless and apneic the entire time she was in EMS care with no shock advised on an of the five cardiac rhythm analysis completed." (Exhibit 1, Tab 9)

[44] St. Paul 4B2 (EMT Trevor Jay Trefankenko, EMT Rachel Sarpalius, and student EMT Gabriel Ibrahim) attended soon after.

[45] A typed statement from EMT Trevor Jay Trefanenko states:

> "We arrived in the patient's bedroom at 8:00:47. Inside the room, EMS crew from St. Paul 1B1 .....were very busy working. One was on the airway (also suctioning the airway), one on the chest doing CPR and Mark was working the AED (automated external defibrillator). Mark was the one in charge sending orders to all EMS staff in the room. Mark delegated my student Gabe to assist with the resuscitation. Rachel and I were delegated by Mark to get further equipment (board and straps) and a history from the bystanders.
>
> From my first observation in the room ..... patient was in severe distress. There was a large amount of orange liquid in and around the mouth, face and upper body. Skin color was cyanotic. There was no chest movement of respirations.....I was asked by Mark to start an intravenous line. I was able to get a 22 gauge catheter into her left hand with normal saline running wide open. We placed the patient onto a spine board and secured her to the board. Stretcher placed into St. Paul 1B1 ambulance and they left the scene at 08:11:12 and they arrived at the St. Paul healthcare at 08:13:55. I remained on scene temporarily gathering EMS equipment and drove second unit to the hospital arriving at 08:20:53. (Exhibit 1, Tab 12)

[46] Mr. Robinson told the Inquiry that the time stamps recorded in the EMT charts were accurate. Mr. Robinson also reviewed and explained significant entries in the patient care records: patient's eyes open; pupils fixed at 5mm; no sign of trauma or distinctive lividity; 300 ml of orange liquid emesis suctioned from the patient's airway.

[47] Patient care was transferred to hospital at 08:15:00.

St. Paul-St.Therese Health Centre ("the Hospital")

[48] The Hospital Ambulatory Client Care Record describes presentation following arrival as follows:

> Nursing assessment: "Pt is mottled & rigid... Monitor shows flat line when CPR is initiated. Dr. Adebayo present. Pt. has emesis covering face & pyjama top. Pupils fixed & dilated – clouds over scleras. Pt is in tight fetal position (normal position for pt) – awaiting surgery tomorrow for contractures."
>
> Physician Assessment: "Pt. brought in by EMS in full code. Already in rigor mortis.....CPR monitor – flat, no shock advised. Vomitus all over her body; pupils dilated & fixed. Abd – distended & rigid. ....Dead on Arrival."
>
> Physician's Orders: "For medical examiner to see. Pt. pronounced dead @ 0817". (Exhibit 1, Tab 10)

The Medical Examiner

[49] An external examination was performed May 27, 2013 (11:35:00 hours) in the Edmonton Offices of the Chief Medical Examiner. (Exhibit 1, Tab 4)

[50] The Certificate of Medical Examiner, signed by Dr. Bannach, describes the circumstances of death as follows:

> "This 18 year old female, with a history of severe global developmental delay and severe flexion contractures, was found unresponsive in her bed. Emergency medical services attended and suctioned vomitus from her airways. She was then transported to hospital where she was pronounced dead."

[51] Torso diagnostic imaging revealed reduced lung volumes and increased intestinal gas.

[52] In a letter to Mr. and Mrs. Lavoie dated November 22, 2013, Dr. Bannach states:

> "After review of the records, it is reasonable to conclude that the terminal mechanism of Cassandra's death .....(resulted from).... the aspiration of stomach contents. This was a natural complication related to and as a consequence of her global developmental delay. In my opinion, the manner of death is therefore classified as natural for medical statistical purposes." (Exhibit 1, Tab 7)

St. Paul RCMP

[53] On May 26th, 2013 (09:50:00), Mr. Chuan Chuck, an Edmonton Medical Examiner Investigator, contacted St. Paul RCMP to instruct investigation and treatment of the fatality as "sudden death". (Exhibit 1, Tab 14)

[54] Cst. J. Dunbar subsequently attended Residence 12 to photograph the scene and to collect witness statements.

[55] Cst. J. Boisvert proceeded to the hospital where he obtained an audio-recorded witness statement from Richard Lavoie at 10:50:00.

[56] Coloured photographs of Cassandra's room taken May 26th, 2013 (10:17:00) indicate a notable area of orange colored material ("vomitus") near the head of the bed (on the right side/supine position) running down the mattress/box spring and pooling on the floor. The bed was positioned against the northeast wall of the room. (Exhibit 1, Tab 30)

[57] Police also attended the hospital morgue to examine and photograph the body. There were no signs of trauma or foul play observed.

[58] The Police Occurrence Summary concludes the death was non-criminal. (Exhibit1, Tab 13).

B. Inquiry Discussion and Findings

[59] There were evidentiary conflicts regarding Cassandra's overnight supervision requirements and health history.

[60] In letters to Dr. Bannach (August 28th, 2013) and to the Fatality Inquiry Review Board (September 26th, 2013), Mr. and Mrs. Lavoie state:

a. *Cassandra ".... vomited at home on occasions, may be on average once a month or so depending on the volume of food she consumed and how she was feeling overall. Cassandra becomes very vocal when she vomits...."*;

b. Cassandra "....*was to be monitored every thirty minutes*". (Exhibit 1, Tab 5)

[61] These two statements do not appear supported by any other documentary or viva voce evidence presented.

[62] To the contrary, Mrs. Lavoie advised the Inquiry that:

a. Cassandra did not require regularly nightly supervision in the family home unless she "woke up screaming";

b. Cassandra had a healthy appetite and tolerated pureed foods;

c. Cassandra did not have a history of emesis other than bouts of flu.

[63] Mr. Bear, confirming this was also his understanding, suggested that Cassandra's visit may have been denied if a history of vomiting were disclosed or close overnight supervision required having regard to the admission criteria, approved funding and staffing in place on the date of her respite stay.

[64] After careful consideration of all the evidence, I am satisfied that Cassandra did not have a history of emesis or require overnight monitoring on regular intervals. Disclosure of such vital information regarding Cassandra's overnight care would have otherwise been noted in the application form and in discussions with staff.

[65] I am satisfied that SPAN frontline staff was only requested and required to provide close overnight response if Cassandra were awake and crying.

MECHANISM OF DEATH

A. Evidence

[66] An autopsy was not conducted in accordance with Mr. and Mrs. Lavoie's wishes.

[67] Dr. Bannach performed a thorough external examination and concluded that the terminal mechanism of death resulted from the aspiration of stomach contents. (Exhibit 1, Tab 7)

[68] Dr. Bannach described this as a natural complication related to and arising from global developmental delay.

[69] There was no other Inquiry evidence presented to support another theory or to augment Dr. Bannach's expert opinion.

B. Inquiry Discussion and Findings

[70] Cassandra's sudden death was natural, unexpected and a terrible shock to the members of her loving family.

[71] However, in the absence of an autopsy or other qualified medical expertise, there is nothing more that the Inquiry can add to the observations and conclusion presented by Dr. Bannach.

TIME OF DEATH

A. Evidence

a) The Medical Experts

[72] EMT Mark Robinson detailed the resuscitation process undertaken at Residence 12 and en route to hospital. Despite continuous efforts, "..the patient's condition never changed. She was pulseless and apneic the entire time she was in EMS care with no shock advised on any of the five cardiac rhythm analysis completed". (Exhibit 1, Tab 9)

[73] Dr. Adebayo's observations are consistent: "Already in rigor mortis.....CPR monitor – flat, no shock advised. Vomitus all over her body; pupils dilated & fixed. Abd – distended & rigid. ....Dead on Arrival." (Exhibit 1, Tab 10)

[74] Although Dr. Adebayo speculated that the patient had been dead for "at least four hours" May 26th, 2013 (08:17:00) following his examination of the body ("stiff"; "stomach – hard and distended"; state of rigor mortis), he told the Inquiry it would be best to defer to Dr. Bannach's expertise.

[75] Dr. Bannach has had conduct of approximately 12,000 such investigations over his lengthy career as a forensic pathologist.

[76] In a preliminary opinion letter dated December 15th, 2016, Dr. Bannach opines that: "the decedent had been dead for more than two hours at the time of the (paramedic's) observation and possibly more than four hours". Dr. Bannach reached this conclusion from his interpretation of certain shorthand notations regarding lividity in the Ambulance Ground Patient Care Records. Lividity is the pooling of blood in the lower portion of the body post mortem which causes discoloration of the skin. Dr. Bannach subsequently learned that he misunderstood these shorthand notations due to the poor photocopy quality of records produced and that there were actually no signs of lividity observed by emergency paramedics. As such, his opinion regarding time of death significantly changed. (Exhibit 3)

[77] Dr. Bannach testified that Cassandra's time of death could not be precisely established from:

a. the decedent's symptoms and presentation because:
    i. signs of rigor mortis (post-mortem rigidity) may have been confused with the significant pre-existing muscle contractures;
    ii. the abdominal distension likely resulted from fluid or gas accumulation in the body cavity itself during resuscitative efforts (having regard to the "soft" abdomen initially documented by paramedics);

iii. the cyanotic blue chest (discoloration caused by inadequate oxygen in tissues) is also observed in individuals during common asthmatic attacks;

b. the stages of rigor mortis as progression is affected by many variable factors;

c. pathological findings on an autopsy (as they do not assist);

d. current scientific means.

The SPAN Staff

[78] Police collected several witness statements from SPAN staff regarding the events of May 26th, 2013. (Exhibit 1, Tabs 20, 22 and 23)

[79] Of these, the statements from the four front line workers on shift between 06:00:00 and 08:00:00 (Emelyn Colina, Suzanne Audette, Atlas Bjorna and Victor Sicat) are particularly relevant.

[80] It is noted that statements from Ms. Colina, Ms. Audette and Mr. Sicat are all typed in the same format style, font theme and font size. (Exhibit 1, Tabs 20, 22 and 23)

[81] Although the two page statement signed by Emelyn Colina describes events she purportedly witnessed, it is presented in the third person narrative:

[82] "At around 07:30, day shift staff checked on Cassie and ***she noticed*** ***her sleeping*** (emphasis mine). *Then at 7:45 am, staff checked on her again and noticed the vomitus on the bed and floor. Staff did a physical check and assessed that Cassie is not responding and stiff. Staff told other staff to call 911 and immediately check pulse and performed CPR."* (Exhibit 1, Tab 20)

[83] Ms. Colina contradicts some of this information in her Inquiry testimony when she confirms she did ***not*** actually see Cassandra sleeping at 07:30. She simply listened at Cassandra's door, did not hear any sound and therefore assumed she was still asleep.

[84] The statement that Ms. Colina ("day shift staff") personally observed Cassandra sleeping at 07:30:00 is repeated in witness statements and incident reports: Victor Sicat (Exhibit 1, Tab 23); Linda Ulliac (handwritten statement/Exhibit 1, Tab 35) and in the Incident Report signed by Trina Cox and Tim Bear. (Exhibit 1, Tab 38)

[85] Ms. Ulliac records:

> "Suzanne checked on Cassandra at 6:55 am. She appeared to be sleeping."
>
> "Emelyn checked Cassandra at 7:30 am. She appeared to be sleeping."
>
> "Emelyn checked Cassandra at 7:45 am. She appeared to be sleeping."

[86] Ms. Ulliac then continues:

> ".....but Emelyn observed a large amount of vomit on the bed and the floor. Emelyn did a closer check on Cassandra and found her – not breathing. There was no pulse and she was stiff."

[87] Ms. Colina immediately called out to Mr. Born-Borja who placed the emergency 911 call.

[88] EMT records the 911 call at precisely 07:54:29, nine minutes after Ms. Colina purportedly found Cassandra at 07:45:00.

[89] Suzanne Audette told the Inquiry that she did not specifically recall all details regarding the care she provided and relied on her typed statement of May 26th, 2013 to give evidence.

[90] This statement indicates that Ms. Audette was on "sleep shift" May 25/26, 2013. At 4:00 am, she woke to Cassandra's screams and immediately attended to her for the next half hour. After ensuring that Cassy was resting comfortably, she herself returned to her own room to sleep. Ms. Audette checked the client again at 06:00:00 and 06:50:00. Cassandra was laying on her right side and appeared to be peacefully sleeping both times. (Exhibit 12, Tab 22)

B. Inquiry Discussion and Findings

[91] Given that there is no scientific basis (on the available objective evidence) upon which the exact time of death can be accurately determined by medical experts, the evidence of SPAN staff provides some assistance.

[92] Ms. Colina and Ms. Audette impressed the Inquiry as sincere, dedicated and caring individuals.

[93] There is no difficulty accepting their evidence as credible.

[94] The reliability of their evidence, however, is a distinct issue. Reliability engages consideration of the witness' ability to accurately observe, recall and recount events in issue.

[95] In reviewing the police statements of May 26th, 2013, the following is noted:

a. Police did not obtain audio-recorded statements from staff witnesses as they did from Mr. Lavoie (May 26th, 2013 (10:50) (See R. Lavoie Transcript: Exhibit 1, Tab 27);
b. There is no indication as to the time the witness statements were made and/or signed in any of the SPAN staff statements;
c. The statements of Ms. Colina, Mr. Sicat and Ms. Audette were typed in the identical format style, font theme and font size;
d. The first four lines of Mr. Sicat and Ms. Colina's statements are essentially identical "word for word";
e. Ms. Colina's statement is narrated in the third person;
f. The misinformation regarding the nature of the "07:30 (May 26th, 2013) check" is repeated in three of the witness statements;
g. Ms. Colina made one handwritten correction to her typed police statement ("stuff" changed to "stiff), but left the important mis-statement that *"she noticed her (Cassandra) sleeping*" at 07:30:00;
h. Ms. Ulliac's handwritten witness statement (Exhibit 1, Tab 25) includes hand written notes inserted by a third party who is not identified;
i. Ms. Ulliac's notes do not state that Ms. Audette checked on Cassandra at 06:00:00;
j. Ms. Ulliac described front line workers as "visibly shaken" (Exhibit 1, Tab 25, page 00038).

[96] Having regard to these matters, it is reasonable to conclude that Ms. Colina's witness statement was prepared by others who may have also assisted with witness statements collected from Ms. Audette and Mr. Sicat.

[97] The desire to assist fellow co-workers in good faith is a natural human response to the morning's tragic events. Unfortunately, however, without knowing the nature of collaboration and influence that may have inadvertently occurred, questions regarding the accuracy of information in the police statements arise.

[98] Given the significant passage of time, it is reasonable that Ms. Audette would not have an independent recollection of certain details regarding Cassandra's care and would have to rely on her 2013 typed police statement as she testified in the Inquiry.

[99] Insofar as her handwritten log entries support her testimony, her Inquiry evidence is reliable. However, having regard to the possibility of witness collaboration and influence as referenced and Ms. Audette's use of certain verbs in the past subjunctive tense *("would have")*, I am not reasonably satisfied that visual checks were **adequately** conducted at 06:00:00 and 06:55:00.

[100] My findings of fact regarding the events of May 26th, 2013 are therefore as follows:

a. Ms. Audette heard Cassandra's cries at 04:00:00 and immediately responded;

b. Ms. Audette changed Cassandra's soiled diaper and mattress soaker pad, gave her a prepared bottle of formula, adjusted her television/DVD, and then soothed and comforted her. Ms. Audette returned to her room to sleep once Cassandra was resting comfortably at approximately 04:30:00;

c. The 911 emergency call was received at 07:54:29;

d. Given that the call was placed immediately following discovery of the client in a non-responsive state, Ms. Colina did not likely enter Cassandra's room until 07:54:00;

e. There were no changes observed to Cassandra's presentation from 07:54:00 to 08:17:00 as described by Ms. Colina ("no pulse"; "no signs of life"), the paramedics ("zero pulse"; "pupils fixed at 5m/ no reaction to light") and the hospital ("dead on arrival"). None of the resuscitative measures undertaken by SPAN staff, first responders or hospital elicited response;

f. Staff did not hear any cries from Cassandra between 04:30:00 (when she was left resting comfortably) and 07:54:00 (when she was found in an unresponsive state);

g. Cassandra's status at 06:00:00 and 06:55:00 is undetermined.

[101] From these findings of fact, I conclude that Cassandra's death on May 26th, 2013 fell between the hours of 04:30:00 and 07:54:00.

SUMMARY OF PROPOSED RECOMMENDATIONS

The Inquiry received four recommendations proposed by the Interested Parties as summarized herein.

Staff Training

Proposed Recommendation #1 (presented by Mr. and Mrs. Lavoie):

Disability support staff should receive enhanced, individualized training to meet the specific needs of severely disabled persons entrusted to their care.

Proposed Recommendation #2 (presented by SPAN/Mr. Bear):

Alberta should adopt minimum standard competencies for all disability support workers.

A. Evidence

[102] Certificates for Ms. Audette, Ms. Colina and Mr. Bjorn-Borja were produced confirming successful training and completion of six courses in 2012 [Standard First Aid and CPR; Food Sanitation and Hygiene; Medication Administration; FOIP review and instruction; Critical Incident Procedures; and Emergency Evacuation]. (Exhibit 2, Tabs 44, 45 and 46)

[103] Mr. Bear (SPAN Executive Director) testified that:

a. SPAN has successfully satisfied the high standards of accreditation on an annual basis for the last 18 years;
b. the accreditation process is an intensive evidence-based assessment conducted by a third party agency to help improve the quality, safety and efficiency of services provided;
c. SPAN's frontline disability support workers require training and certification as follows:
    i. Foundations in Community Disability Services (an accredited 80 hour course which covers core competencies);
    ii. First Aid and CPR;
    iii. Positive Behavioural Support Resources and Practises;
    iv. Abuse Reporting Protocols;
    v. Medication Administration for Para-Professionals;
d. SPAN strongly advocates minimum competencies for all disability support workers across the province;
e. Alberta has not adopted minimum competencies for disability support workers due to the consequent increased labour costs;
f. Government funding at levels sufficient to provide commensurate remuneration and benefits is required in order to improve recruitment of suitable candidates, to reduce staff turnover, and to ensure the delivery of consistent, high quality care.

B. Inquiry Discussion and Findings

[104] The Inquiry did not receive any evidence or submissions to identify defined gaps in core competency training or service delivery having regard to the complex needs of the severely disabled in the care of SPANM.

[105] The Inquiry accepts that the training and qualifications of SPAN front line staff is high relative to current provincial standards as evidenced by its past record of accreditation success.

[106] The Inquiry strongly agrees in principal that minimal competencies for all disability support staff should be mandatory.

Overnight Staffing

Proposed Recommendation #3 (presented by Mr. and Mrs. Lavoie):

> **Severely disabled persons in care should receive careful overnight monitoring at regular intervals**.

A. Evidence

[107] Although Mrs. Lavoie acknowledged that Cassandra did not have regular overnight checks in the family home and that there was no communication of such expectations to SPAN staff, she nonetheless assumed there would be such checks in thirty-minute intervals.

[108] Mr. Bear testified that:

a. SPAN's policies regarding overnight "awake" staffing accord with the identified needs of each individual client as assessed and approved by PDD;

b. Cassandra's medical health history and caregiving requirements as communicated to SPAN did not disclose or support close overnight supervision and monitoring;

c. SPAN has recently implemented a policy that mandates semi-hourly checks on all new residential clients in the first 24 hours following admission.

B. Inquiry Discussion and Findings

[109] There was no evidence presented in the Inquiry as to the frequency and nature of overnight monitoring that would suitably serve the needs of severely disabled persons in care.

[110] Such assessments are mandatory before admission having regard to the unique and highly complex needs of each client and the available services of the proposed facility.

[111] The frequency and nature of overnight monitoring is a critical consideration and appropriately the purview of PDD.

[112] The Inquiry has nothing meaningful to add.

Resources

Proposed Recommendation #4 (presented by Mr. and Mrs. Lavoie):

> **SPAN should have monitoring equipment and other resources available to help alert staff to a client in distress*.***

A. Evidence

[113] Mrs. Lavoie stated the family home had a "special mattress" to monitor Cassandra's heart rate and a "baby monitor" to detect movement and sound. Although the subject was not raised or discussed, Mrs. Lavoie assumed that SPAN facilities were equipped with such devices.

[114] Ms. Colina testified that CPR (cardiopulmonary resuscitation) was administered to Cassandra as she lay supine on her bed as they did not have a spine board in their facility.

[115] Upon arrival, paramedics immediately moved Cassandra to the floor for CPR and other resuscitative measures. Mr. Robinson (primary EMT) explained that a soft surface does not accommodate adequate chest compressions. CPR would therefore be ineffective.

[116] Ms. Colina also testified that it is her preferred practise to close the door to her bedroom and the bedrooms of each client when she works an overnight "sleep" shift.

[117] Mr. Bear testified that:

a. SPAN facilities are not medical/health centres;

b. third party accreditation agencies have not recommended special monitoring equipment in SPAN residential facilities;

c. visual and auditory monitoring devices pose privacy and other important concerns;

d. the purchase, installation, maintenance and proper use of monitoring equipment would necessitate additional PDD funding to cover capital cost and additional staff training and resources in a fiscally challenged economic climate;

e. "low tech" monitoring equipment for non-commercial use is unreliable and failure prone;

f. SPAN's exposure and liability risk would consequently increase.

B. Inquiry Findings and Discussion

i) Audio/Visual/Health Monitoring Devices

[118] Extraordinary advances in the world of electronics have occurred in recent years turning science fiction into science fact. Mobile home security software applications facilitate instant visual and audio communication with visitors at your front doorstep from thousands of miles away. Wearable/wireless health technologies monitor exercise, sleep, weight, heart rate, and significant other physiological data. There is a wide selection of devices, affordable and user-friendly, in the general market.

[119] Such technology would undoubtedly help alert attention to those in serious distress, thereby improving emergency medical response and potential successful outcomes.

[120] This Inquiry is also satisfied, however, that there are many factors to consider and competing interests to weigh. Signals of simple devices such as baby monitors, for example, received by outside third parties, compromise privacy rights of the client and the facility itself.

[121] In absence of any specific evidence regarding the practical feasibility of integrating specific devices into group homes at this time and noting the strong conflicting submissions presented by counsel, the Inquiry yields such discussions and considerations to PDD, third party accreditation agencies and other stakeholders and experts in the field tasked to protect persons in care.

[122] The Inquiry adds one small caveat, however. When there are no "awake" staff members on overnight shifts, it is recommended that doors to staff and client bedrooms (where appropriate and reasonable) remain open as staff and clients sleep. A support worker in deep sleep may not otherwise hear the quiet moans of a severely disabled person in distress. Staff must be attentive and responsive to occurrences at all times when vulnerable persons are in their care.

ii) Cardiopulmonary Resuscitation

[123] The evidence established that SPAN staff commenced CPR on Cassandra's bed because a spine board was not available. Upon arrival, paramedics immediately transferred Cassandra from bed to floor as CPR chest compressions should occur on a hard surface to ensure optimal perfusion.

[124] Where the transfer of a subject to the floor is difficult, and CPR occurs on a soft surface, a spine board is necessary. Short spine boards (lightweight, durable, engineered plastic) are available online at nominal cost.

[125] Disability support staff should also receive refresher CPR instruction and safe spinal-board transfer techniques given that such life altering skills, if not rehearsed or used, may be lost in momentary panic.

Records, Communication and Charting

A. Evidence

[126] The Inquiry received PDD/ SPAN's complete file regarding Cassandra's application for long-term care and respite stay.

[127] The forms, charts, records and authorizations produced are as follows:

a.	PDD Contact Notes	10/13/2011	Exhibit 2, Tab 77
b.	PDD Health & Safety Assessment Form	11/06/2011	Exhibit 2, Tab 78
c.	PDD Eligibility Form	11/21/2011	Exhibit 2, Tab 76;
d.	PDD Adaptive Skills Inventory	11/23/2011	Exhibit 2, Tab 78
e.	SPAN Application Form	01/19/2012	Exhibit 1, Tab 35;
f.	SPAN Agency Medical Form	02/17/2012	Exhibit 1, Tab 36;
g.	SPAN Consent to Release Information	09/21/2012	Exhibit 1, Tab 32;
h.	SPAN Consent to Services Form	09/21/2012	Exhibit 1, Tab 37;
i.	SPAN Intake Survey	09/21/2012	Exhibit 1, Tab 39
j.	SPAN Field Trip Consent Form	09/21/2012	Exhibit 1, Tab 40
k.	SPAN Medication Consent Form	09/21/2012	Exhibit 1, Tab 41
l.	SPAN Policy Manual Acknowledgment	09/21/2012	Exhibit 1, Tab 42
m.	SPAN Service Planning Consent Form	09/21/2012	Exhibit 1, Tab 43
n.	Mrs. Lavoie's Instructions (handwritten)	05/25/2013	Exhibit 1, Tab 33;
o.	"Cassie's Daily Log"	05/25/2013	Exhibit 1, Tab 34;
p.	SPAN Incident Report	05/26/2013	Exhibit 1, Tab 38

[128] Mr. Bear (SPAN) confirmed that a client-specific "individual service plan" is not created until the client has resided in long-term care for a period of 45 days.

B. Inquiry Discussion and Findings

[129] Rightly or wrongly, Mr. and Mrs. Lavoie made assumptions that Cassandra would receive semi-hourly supervision and care and other forms of monitoring. The limited charting information regarding her last few hours of life raised suspicions and concerns.

[130] Their questions have firmly grounded this Inquiry.

[131] The SPAN application for long-term care is dated January 21, 2012, sixteen months before Cassandra's afternoon visit (May 23, 2013) and overnight stay (May 25, 2013).

[132] Other than Mrs. Lavoie's short handwritten note of instructions to staff, there is no formal procedural intake or questionnaire to determine the client's current status, needs and plan of care as at the May 25th, 2013 date of admission.

[133] The timely collection of client information and maintenance of records has six primary functions:

a. assessment of needs and risks;

b. planning and delivery of appropriate care and activity;

c. continuity and coordination of services;

d. program evaluation;

e. accountability;

f. transparency.

[134] While long-term care residents may have carefully documented charts and specific service plans, Cassandra's file reveals significant gaps.

[135] Whether visits to residential facilities are arranged for respite or assessment for long-term placement (collectively referred to as "respite"), record keeping should occur as follows:

a. Respite Intake Process: clients/guardians should receive all relevant information regarding supervision and care to help them decide (before admission) whether SPAN's services will meet their expectations and needs;

b. Respite Intake Questionnaire: to document client's current health status and needs. It should include detailed questions about: disability; medical history; allergies; vaccinations; medications; food tolerance; bowel habits; social and emotional expression and needs; speech and language comprehension; daily activities; sleep patterns/routines; bathing requirements/routines; monitoring devices and safety equipment used in the home; and so on and so forth. Information regarding overnight monitoring (none/ intermittent intervals/ constant) should be carefully elicited and documented;

c. Respite Intake Care Plan: to outline the proposed activities that will be provided. If there is only a "sleep" shift scheduled for overnight care, the client/guardians should be informed and their consent documented;

d. Admission and Discharge Authorization: should document admission and discharge date and time with requisite signatures.

[136] These standard authorizations, questionnaires and forms do not appear or alternatively, are not updated on Cassandra's file. When there are long gaps between visits or the collection of information, records must be updated as there may be important changes along the disability spectrum.

[137] It is acknowledged while SPAN residential facilities are not medical centres, the format of the "Cassie's day log" produced (Exhibit 1, Tab 34) is skeletal and does not permit adequate recording of essential care information.

[138] Every disability client file should log:

a. Food Intake: the time the client was fed, the nature of food consumed, the amount consumed;

b. Diaper Changes and Movements: the time diaper was changed; whether there was a bowel movement;

c. Bed Checks: the time the bed check was performed and observations made (client's eyes open/closed/breathing);

d. Day Activities: the time and nature of activities enjoyed.

[139] Inquiry impressions regarding the overnight safety of clients should also be noted.

[140] When bed checks are performed, sight and sound supervision should be unobstructed. Staff, equipped with working flashlights, should remain in the room long enough to confirm the client is alive, not in distress and asleep.

[141] A bed check outside the client's bedroom door or a glance into a dark room is inadequate.

RECOMMENDATIONS

[142] Cassandra Marie-Ange Lavoie's family expressed their sincere hope that "something good" would come from an Inquiry into the circumstances of their beloved daughter's sudden and unexpected death on May 26th, 2013.

[143] Although questions remain about the precise circumstances, mechanism, and timing of death, this Inquiry is satisfied that Cassandra received competent and compassionate care.

[144] The evidence, however, also revealed certain gaps and risk factors that invite assessment and review.

[145] While it is recognized that none of the recommendations herein would have likely prevented the tragic outcome of this case, a "best practises" perspective may help manage future risk and reduce potential harm.

[146] Having regard to the findings expressly made, this Inquiry recommends that:

I. Minimal Core Competency Standards

Alberta adopts the establishment of minimum core competency standards. Disability support staff must have the knowledge, skills and ethical compass to perform a wide array of tasks for the protection and safety of vulnerable clients entrusted to their care. The use of basic competencies to set workforce development and training will contribute to successful job performance, improve workforce retention, enhance the quality and delivery of services, and promote the inclusion, dignity, value and respect to which all disabled persons are entitled;

II. Records, Communication, and Charting

PDD (with the assistance of accreditation agencies) review intake questionnaires and procedures, forms, charting and record keeping for respite and related client care. Comprehensive communication among stakeholders is critical for client protection and safety, transparency and accountability. Forms and questionnaires are functional tools to understand and assess the client's most current health status (medical/physical, emotional),

demands, and needs. They also serve to inform consent, to manage expectation and to foster trust;

III. Overnight Supervision and Care

PDD review "sleep shift" practises and "bed check" procedures to ensure that staff is attentive and responsive to occurrences regardless of the hour having regard to their vulnerable clients;

IV. Lifesaving Resources and Technique

PDD consider refresher CPR instruction and related essential resources given the unpredictable life altering emergencies which their disability support staff may encounter.

DATED September 20, 2018,

St. Paul, Alberta, Alberta.

Original signed by

Rosanna M. Saccomani
A Judge of the Provincial Court of Alberta