REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at Rimbey Provincial Court Building

in the Town (City, Town, etc.) of RIMBEY (Name of City, Town, etc.)

on the 29th day of October, 19 92 ~~and by adjournment~~

on the _____ day of _____, 19____), before

D.J. PLOSZ, a Provincial Court Judge.

A jury ☐ was ☒ was not summoned and an Inquiry was held into the death of

[redacted] (Name in Full) (Age)

of R.R.#2, Westerose, Alberta (Residence) and the following findings were made:

Date and Time of Death February 29, 1992 between 12:20 a.m. and 6:00 a.m.

Place Whispering Hope Residence, Bluffton, 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 — The Fatality Inquiries Act, Section 1(d))

Asphyxia due to aspiration

Manner of Death ("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable — The Fatality Inquiries Act, Section 1(g))

See attached

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CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

See attached

No. of additional pages attached _____

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

See attached

No. of additional pages attached _____

DATED this 19TH day of NOVEMBER 19 92.

A Judge of the Provincial Court of Alberta

MANNER OF DEATH

The evidence of the local Medical Examiner, Dr. M. D. Nawrot of Rimbey, was that the deceased died from asphyxia due to aspiration, that is, a lack of oxygen due to blockage of her airways. In his Certificate Of Medical Examiner, Dr. Nawrot presumed this, after finding out how the deceased had been found, his examination of the deceased at the Rimbey Hospital, and his being advised of the results of the autopsy. The pathologist, Dr. C. Hegedus concluded that the deceased died probably as a result of asphyxia. Based on the autopsy alone, the pathologist could not definitely say what the cause of death was. He took this position because he said he could find nothing blocking the airways of the deceased at the time he conducted the autopsy. However, he stated that it was not uncommon for blockage of the airways to be cleared out by ambulance attendants in this type of case, when they attend the scene. Neither doctor, in testifying, could offer any other explanation as to how the deceased had died, and the evidence therefore leads one to the inescapable conclusion that death did occur from asphyxia due to aspiration and in this case, the manner of death is found to be accidental.

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

[redacted] who was severely mentally handicapped from birth. She had the functional capability of a two or three month old infant. She was unable to do anything for herself. She could not crawl or walk or raise her hands. She could not speak. Her only methods of communicating were by jerking her head back and forth and crying. She lived in a foster home. Her foster parents took her to the Whispering Hope residence at Bluffton, Alberta, which is a group home for handicapped children run by Hannah and Alfred Matson. The Matsons had run this home for 25 years. On Friday, February 28, 1992, the deceased's foster parents took her to the Matson's group home for the weekend in order to have a break for themselves, as the deceased needed constant attention. The Matsons took her on Friday, February 28 at approximately 3:40 p.m. They had looked after the deceased at Christmas time in 1991 for five days without any difficulty. Mrs. Matson pureed the deceased's food at supper time, fed her, and then at approximately 6:00 p.m. Mrs. Matson put her to bed as that seemed to make [redacted] the most comfortable. She was in a hospital standard type crib. Mrs. Matson tried to give her a pillow but she seemed uncomfortable with that. Mrs. Matson put her on her back eventually in bed as she had tried to first put [redacted] on her side and stomach but [redacted] did not like that, so she put her on her back and [redacted] seemed most comfortable in that fashion. [redacted] was still awake at 8:00 p.m. and appeared comfortable. Mrs. Matson was in the livingroom a short distance away. She kept going in

periodically to check [redacted] At midnight Mrs. Matson checked on her again. [redacted] was sleeping and breathing normally. No spittle or vomit was evident at that time. [redacted] was still lying on her back. Mrs. Matson stayed with her until 12:20 a.m. at which time she herself went to bed. The doors were open to [redacted] bedroom as well as to the Matson's bedroom. Both Mr. and Mrs. Matson were not awakened during the night with any unusual sounds or behaviour from any of the children staying at the house at the time, including [redacted] Mr. Matson awoke early on Saturday morning at 5:15 a.m. A short time later he checked on [redacted] and found that she was lying on her back with no sign of life. There was vomit on her right shoulder and around her mouth. The largest amount of vomit was on the floor and he concluded that she must have tossed her head in order for the vomit to get on the floor. There was no sign of anything untoward or any struggle. [redacted] appeared deceased. The police and ambulance were called. The Medical Examiner, Dr. Nawrot, did not attend the house. He only examined the body at the hospital once it was brought there by the ambulance attendants. When Mr. Matson found her, [redacted] was very stiff and cold to the touch.

When the foster parents had brought [redacted] to the Matsons in December of 1991, they had given instructions to the Matsons as to how to prepare [redacted] food and care for her. There were no special or different instructions given to them on the 28th of February when [redacted] was left with them. In fact, no instructions at all were given by the foster parents at that time. Therefore, Mr.

and Mrs. Matson dealt with the child exactly as they had dealt with her in December. They were not aware of any problems with [redacted] vomiting and she did not do anything like that in December when she was with them. They were not aware of any history of vomiting that would cause them any concern.

The pathologist indicated that the autopsy revealed that both lungs of [redacted] indicated evidence of previous aspirations; however, he did not attribute that to the death.

This was a child who was completely incapable of looking after herself, or of communicating, or even moving around. Everything had to be done for her, just as it would have to be for a two or three month old infant.

The inescapable conclusion is that some time between 12:20 a.m. and approximately 5:15 a.m. on February 28, 1992 [redacted] vomited her partially digested food and this caused her to choke to death.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

While Dr. Nawrot testified that this death could have been preventable if [redacted] had been positioned in bed such that their airways always remained clear and open, this would have required constant 24 hour nursing care, as [redacted] did not have the capacity to protect her own airways. However, in this case, the evidence did not disclose that anyone knew of [redacted] having a history of vomiting such as occurred on this occasion and therefore, 24 hour supervision was not given by the Matsons. She was treated, in that regard, as any two or three month old infant would be. Given the circumstances of this case including the medical condition of the deceased, the only recommendation that could be made for prevention of similar deaths would be that 24 hour supervision would be appropriate, in cases where there has been a demonstrated pattern of vomiting or other respiratory problems that could cause asphyxiation.