September 27, 2017

Ms. Amy Deyell
Alberta Health Services
10301 Southport Lane SW
Calgary AB T2W 1S7

Dear Ms. Deyell:

Subject: Sharon Grace Lewis – Public Fatality Inquiry
Response to Recommendations

Please find enclosed a copy of the Honourable Judge Janet L. Dixon’s report to the Minister of Justice and Solicitor General. This report will be publicly released on October 18, 2017.

The following recommendations made by Her Honour may impact Alberta Health Services:

1. That RAH management develop a policy or department standard that integrates Gaming and Liquor Apprehensions (security policy standard) with a health standard to ensure security and health staff work cooperatively to assess and respond to the social and health circumstances of every individual apprehended by security for intoxication on RAH property throughout the period the individual is held “in custody” or otherwise detained awaiting EPS response; these individuals should be under some form of admission to the RAH during the period of custody to ensure dual responsibility for the wellbeing of the individual. This will also enable a person in custody to be assessed for participation in the various program initiatives introduced at RAH for high risk individuals.

2. That RAH management, in conjunction with Alberta Health Services, develop a reliable database to record incidents of Microsan misuse by patients, clients or visitors. This database should integrate RAH incidents and security operation incidents of misuse. A manager should be assigned to be responsible for reviewing each incident to assess how the Microsan was accessed and to revise strategies for securing the Microsan to avoid future misuse.
3. That RAH management provide an ongoing program for all patient care units, including ICU and emergency department, to educate professional staff on the challenges of addictions and the importance of admitting individuals to ensure access to the enhanced supportive programs being offered for these individuals.

4. That RAH management develop strategies to implement the immediate assessment and development of accelerated discharge plans for individuals who are patients by virtue of being in custody under s. 115 of the Gaming and Liquor Act, assuming Recommendation A is implemented. (sic)

5. That RAH management develop a policy or standard, and supportive procedures to provide guidance to and educate professional staff regarding the appropriate considerations in deciding whether or not to issue a Form 1 and Form 3 under the Mental Health Act. Specific guidance should be provided for circumstances where a patient leaves a unit during the course of an assessment prior to the risk assessment being complete. In those circumstances the patient should not be coded as discharged until the responsible physician has authorized the discharge.

6. That RAH management review discharge policies and procedures for individuals who have been certified during the course of their admission. Procedures should be revised to provide enhanced care and support on discharge and to consult with a psychiatrist whether a patient should be re-certified if the discharge plan is not successfully implemented.

7. That RAH management develop a shared database with security staff including admissions and discharges for the prior seven days. Flags should be developed for discharged patients who have not been transported to the discharge destination immediately upon discharge or whose discharge plans have not been implemented.

I ask that you please advise the following:

1. Whether Alberta Health Services accepts, accepts in principle, does not accept, or has a different response to each recommendation;

2. A brief explanation of why those decisions were made; and

3. If Alberta Health Services intends to accept a recommendation, or to implement different measures, what steps will be taken in that regard.

A response to this enquiry is not mandatory. However, please be advised that any response received will be publicly released and posted on the Open Government Portal:


If a response has not been received by February 20, 2018 (four months from the public release of Judge Dixon’s report), that information will also be made publicly available.
Please ensure the response does not include any personal third party information.

Thank you for your cooperation in this matter.

Yours truly,

Jennifer Fuchinsky
Fatality Inquiry Coordinator
Enclosure