ALBERTA

Report to the Minister of Justice

Fatality Inquiries Act

Public Fatality Inquiry

WHEREAS a Public Inquiry was held at the Law Courts

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

on the 14th-15th day of July, 2021 (year), (and by adjournment

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

before Carrie J. Sharpe, a Justice of the Alberta Court of Justice,

into the death of Kaitlind Credgeur (Name in Full) 25 (Age)

of Edmonton, Alberta (Residence) and the following findings were made:

Date and Time of Death: June 22, 2018, at approximately 0840 hours

Place: Alberta Hospital Edmonton

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)).

Plastic Bag Asphyxia

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)).

Suicide

Classification: Public

Circumstances under which Death occurred:

Overview:

Kaitlind Ann-Louise Credgeur was born February 16, 1993.

On June 20, 2018, at approximately 1630 hours, Ms. Credgeur was admitted to the Royal Alexandra Hospital [RAH] following an intentional medical overdose and reported feelings of depression. The Emergency Room physician placed Ms. Credgeur under a Form 1 Certification. Ms. Credgeur agreed to be transferred to Alberta Hospital Edmonton [AHE] and was admitted voluntarily at approximately 2132 hours on June 21, 2018.

Ms. Credgeur's personal belongings accompanied her from the RAH to AHE in a plastic bag secured with an elastic.

Once at AHE, Ms. Credgeur was placed on 15-minute observations. The last recorded observation occurred at 0800 hours on June 22, 2018. She appeared to be sleeping.

At approximately 0825 hours., Ms. Credgeur's roommate advised AHE staff that Ms. Credgeur was unresponsive. Staff responded and discovered Ms. Credgeur with a plastic bag around her head, secured with an elastic band. Cardiopulmonary resuscitation [CPR] was initiated but was unsuccessful.

Ms. Credgeur was pronounced deceased at approximately 0840 hours on June 22, 2018. Emergency Medical Services, Edmonton Fire Department, and Edmonton Police attended AHE. All attempts at resuscitation were, tragically, unsuccessful.

A. Immediate aftermath of this incident:

A Public Fatality Inquiry was directed. The proceedings commenced on July 14, 2021, and concluded on July 15, 2021. Mr. John-Marc Dube appeared as counsel for the Alberta Minister of Justice and Attorney General. Ms. Chelsey Bailey, counsel for Alberta Health Services, and Ms. Katherine Fisher, counsel for Dr. Ubaidullah Abdullah, were given leave to appear as interested persons pursuant to s. 49.2(d) of the *Fatality Inquiries Act*. Personal representatives and next-of-kin of the deceased, Mr. Carl Nilsson, and Ms. Karina Credgeur attended and participated in the Fatality Inquiry.

B. Preliminary matters at the Fatality Inquiry:

A Pre-Inquiry meeting was held with counsel on June 15, 2021. At that meeting, agreement was reached as to the issues to be determined at the Inquiry.

They are as follows:

1. The availability of and access to items suicidal individuals use to potentially commit suicide, specifically, the property the individual is admitted to the hospital with; and

2. The level and frequency of observation of suicidal individuals.

C. The Inquiry

The Inquiry began on July 14, 2021, and concluded on July 15, 2021. A number of exhibits were entered, including, but not limited to, hospital documents, Emergency Medical Services and Edmonton Police Service reports, and AHE policies and procedures. Five witnesses were produced by counsel for the Minister of Justice to testify in this Inquiry: Dr. Ubaidullah Abdullah, Kelley Olson, Kiera Burns, Edwin Yee and Mark Snaterse. There were no applications by other counsel to produce or examine any further witnesses.

i. Viva Voce Evidence:

Viva Voce Evidence of Dr. Ubaidullah Abdullah:

At the time of Ms. Credgeur's death, Dr. Abdullah was a staff psychiatrist at AHE. He had been employed at AHE since 2012. Dr. Abdullah graduated from medical school in Afghanistan. He obtained his medical license in 2006 and completed his residency program in psychiatry at the University of Alberta in 2012.

AHE is a psychiatric facility which houses approximately 300 patients in different modalities from young adults to adults, acute adult to rehabilitation. There are also patients with intellectual disabilities and pervasive developmental disorders. There is also a forensic unit.

Dr. Abdullah described the goal of psychiatrists employed by AHE as evaluating, assessing, and diagnosing patients with a view to treatment. The majority of his work involves re-integrating a patient to the community and connecting them with a community support team.

Doctors at AHE interact with patients on a daily basis who are at risk of suicide.

In June of 2018, a young adult unit existed, specializing in the treatment of patients aged 18 to 26. Ms. Credgeur was admitted to Unit 12(a) at AHE on June 21, 2018. This unit consists of 20 beds for young adults. Most of the patients have a primary diagnosis of mental illness, early psychosis, or effective disorder for personality or substance.

Dr. Abdullah was the doctor on call that evening. His shift began at 2100 hours. When Ms. Credgeur arrived at AHE, Dr. Abdullah consulted with a psychiatrist, Dr. Reid, at the RAH by telephone. As well, he reviewed her medical records. Dr. Abdullah met with Ms. Credgeur at approximately 2200-2230 hours for at least 30 minutes. He reviewed her symptoms, her risk, and performed a physical examination. He identified a care plan, which included a determination of what the level of observation should be.

In speaking with Dr. Reid, Dr. Abdullah was advised that Ms. Credgeur was admitted to RAH following an overdose of medication. She presented with a pre-existing diagnosis of depression and anxiety and some history of emotional dysregulation and self-harm behaviour. Dr. Abdullah indicated that Ms. Credgeur was cooperative and expressed that she was depressed and anxious. He noted that she presented with a restricted affect. She expressed a willingness to remain in the hospital and to accept help. Ms. Credgeur was admitted voluntarily. She was assessed not to pose any immediate danger to herself or others. The presenting complaint for Ms. Credgeur upon admission was that she was suicidal and had attempted an overdose. However, she did not voice any current suicidal intent or plan. Dr. Abdullah described her state as passively suicidal, rather than actively suicidal. Ms. Credgeur verbalized that she had been struggling with depression and

anxiety since the age of eight. Her depression had worsened over the previous three months. There had been a change in her appetite, interest, sleep, as well as her concentration, and an increase in suicidal thoughts. Dr. Abdullah noted that Ms. Credgeur had a history of self-harm behaviour, suicidal ideation, and overdosing. Upon presenting at AHE, she had been taking Escitalopram, which is an anti-depressant medication.

Dr. Abdullah recommended close observation of Ms. Credgeur, which means that she would be observed every 15 minutes by a nurse or psychiatric aide. He also recommended that she not be given any grounds privileges or passes to move about the grounds freely until a further assessment could be completed. Ms. Credgeur would have been further assessed by another psychiatrist the morning of June 22, 2018.

Dr. Abdullah received a "code blue" page at 0825 hours on June 22, 2018, to attend Ms. Credgeur's room. He found her unresponsive lying supine on the bed. She did not respond to verbal cues. She was not breathing and no heartbeat could be detected. CPR was attempted but was unsuccessful. She was pronounced deceased. Although the time of death cannot be determined with significant accuracy, Dr. Abdullah estimated Ms. Credgeur to have been deceased for between one hour and four hours when she was discovered as described.

Both nurses and psychiatric aides are responsible for observing a patient at the ordered intervals, in this case, every 15 minutes. At the time Dr. Abdullah ordered this level of observation, he did not believe a more intrusive level of observation was required. Dr. Abdullah testified that some patients are allowed to keep their own clothing. He was unaware as to what items Ms. Credgeur was allowed to keep.

Viva Voce Evidence of Kelley Olson:

Ms. Olson is a registered psychiatric nurse. She has been working in that role for 10 years. Prior to maternity leave, she was a psychiatric nurse working on Unit 12(a) at AHE. She worked on that unit for seven years. She described her duties on Unit 12(a) as documentation, interacting with patients, physical and mental health assessment, and medication administration. These assessments occur during every interaction with a patient. At any given time, there were three nurses on Unit 12(a). As well, there were usually two psychiatric aides. Typically, each nurse would be assigned to seven patients. When a new patient is admitted, the nurses are advised of the frequency of observation ordered by the doctor. That information is kept in a binder. As well, the frequency of observation is noted on a whiteboard at the front of every unit.

Ms. Olson advised that on June 22, 2018, she started her shift at 0700 hours, the morning after Ms. Credgeur was admitted. Ms. Olson was not assigned observations of Ms. Credgeur. Ms. Olson was sitting at the nurses' station checking her charts. Ms. Credgeur's roommate began banging on the glass and was visibly distressed. The roommate advised that Ms. Credgeur had a bag over her head. Ms. Olson ran to Ms. Credgeur's room. It took her a matter of seconds to get there. She noted that there was a blanket completely covering Ms. Credgeur, so it wasn't obvious that there was a bag over her head. Once the blanket was removed and Ms. Olson observed that there was a bag over Ms. Credgeur's head, she removed the bag, called out a code blue, yelled out to one of the psychiatric aides, and pressed the alarm. Ms. Olson observed that there was something tighter around Ms. Credgeur's neck securing the white plastic bag, but she cannot say what that was. The alarm is a panic alarm for violence, but Ms. Olson activated the alarm as she

knew the response to it would be immediate. The psychiatric aide placed Ms. Credgeur on the floor and started CPR. The crash cart and automated external defibrillator [AED] were brought into the room. She recalls the AED being placed on Ms. Credgeur. Ms. Olson was one of the individuals who performed CPR on Ms. Credgeur. As she had just returned to work from maternity leave, she had been recently re-certified in CPR. All staff are required to be certified in CPR.

Viva Voce Evidence of Kiera Burns:

Ms. Burns is a registered psychiatric nurse employed at AHE. Specifically, she works on the young adult unit, Unit 12(a). She began her career at AHE in January of 2017. Ms. Burns was working on June 21, 2018. Her shift began at 1500 hours and ended at 2315 hours. Ms. Burns created notes from information she was provided about Ms. Credgeur. These notes included comments that she was brought to the RAH as a result of an overdose on polypharmaceuticals. She displayed a low mood and was feeling hopeless. A history of deliberate self-harm and suicide attempts was noted. The notes also indicated past trauma, a diagnosis of social anxiety, and past legal issues. It notes an original diagnosis of Major Depressive Disorder. When Ms. Credgeur arrived, she was placed on 15-minute observations with no grounds privileges, which is standard. The only exception is when the transfer orders indicate a patient should be placed on constant observation, which was not the case with Ms. Credgeur. Ms. Credgeur was assigned to Room 2, which was at a distance of approximately 100 metres from the nursing station. Placement of a patient in a particular room is usually based upon bed availability on admission.

Ms. Burns met with Ms. Credgeur for approximately 30 minutes when Ms. Credgeur arrived at 2150 hours on June 21, 2018. Ms. Burns notes that Ms. Credgeur was very pleasant. She was appropriate in her conversation and easily engaged. She was forthcoming with information when asked questions. Ms. Credgeur was noted to present with passive suicidal ideation. As described by Ms. Burns, passive suicidal ideation is when someone is having thoughts of wanting to kill themselves, but does not display with the actual plans to commit suicide (which would be classified as active suicidal ideation). When questioned about her suicidal thoughts, Ms. Credgeur indicated that she had them, but she had no plans to act on these thoughts and no specific means of carrying them out. Ms. Burns indicated that Ms. Credgeur did not appear to be an imminent risk based on her assessment, and that is why she did not request that Ms. Credgeur be placed on constant observation. Ms. Credgeur was provided with a standard document containing 24 questions. The questions are based on the patient's mental state for the week prior to being admitted to AHE. The questionnaire is to be completed by the patient when they are able. This questionnaire had not been received prior to Ms. Credgeur's death.

Ms. Credgeur's belongings arrived with her from RAH. Ms. Burns does not have a specific recollection of what Ms. Credgeur's personal belongings arrived in, but notes that belongings usually arrive in a patient possession bag. These bags are plastic and approximately half the size of a garbage bag. Those belongings were searched for valuables and anything such as sharp objects, belts, cords, medication, etc. If any of those items had been found, they would be withheld.

At the time of admission, Ms. Burns did not have any concerns with providing Ms. Credgeur her belongings in a plastic bag. Ms. Burns last observed Ms. Credgeur at 2300 hours on June 21, 2018, just prior to her shift ending at 2315. At that time, Ms. Burns noted Ms. Credgeur to be awake. Generally, the nurse in charge performs the first and last observations of the shift.

Although Ms. Burns was not the nurse in charge, she performed the last observation of Ms. Credgeur prior to the shift change. Usually, throughout the shift, the psychiatric aides will perform the required observations. If a patient is asleep, the nurses are trained to confirm three respirations; watching the patient's chest rise and fall three times. If the patient is awake, that notation is made.

There appears to have been an observation missed at 2315 hours on June 21, 2018. Ms. Burns is unable to provide any information about that, given that her shift ended at 2315. Ms. Burns indicated that there are situations where an observation may be missed, due to the nurse in charge being required to provide reports on all 20 patients to the incoming nurse in charge, or where there is an emergency situation where all staff are required. Ms. Burns' practice is to enter the room to complete the observation, whether day or night. If at night, she utilizes a flashlight. She expects that to be the practice of all nurses and psychiatric aides. The last interaction Ms. Burns had with Ms. Credgeur was when she was leaving at the end of her shift. She noted Ms. Credgeur to be walking around the hallways. Ms. Burns said goodbye to Ms. Credgeur when she left.

Unless a patient requests to have their lights remain on, all bedroom lights are turned off for the night. There are approximately four lights that are left on at the nursing station. Ms. Burns described the lighting at night as dim. The unit lights are turned on again at 0715 hours. Generally, the bedroom lights are turned on at approximately 0800 hours when the patients get up for breakfast.

Viva Voce Evidence of Edwin Yee:

Mr. Yee was employed by AHS at AHE on June 22, 2018. He was working on Unit 12(a). He had been a nurse at AHE since 2012, and on Unit 12(a) since the end of 2013. Mr. Yee is a registered nurse and graduate of the University of Alberta. He has been employed at AHE since graduating. There were approximately 20 patients on Unit 12(a) during the day shift on June 22, 2018. The charge nurse would typically be responsible for six patients, and two further nurses would be responsible for seven patients each. Mr. Yee was the charge nurse the morning of June 22, 2018. Mr. Yee's shift began at 0700 hours that morning. Upon his arrival at 0700 hours, he received a verbal report from the outgoing charge nurse regarding all patients on the unit. At the start of his shift, Mr. Yee completed an assessment form regarding Ms. Credgeur. The majority of the information relied upon to complete that form would have come from the emergency department at RAH. The form is completed taking into account information supplied from the previous two weeks.

Mr. Yee conducted a scheduled observation of Ms. Credgeur at 0700 hours on June 22, 2018. Mr. Yee observed Ms. Credgeur's chest to rise and fall three times and recorded that she was asleep. The last observation of Ms. Credgeur was noted to be at 0800 hours. When Ms. Credgeur's roommate notified staff at approximately 0820 hours, Mr. Yee was on his break in the staff room. A code white alarm was heard by Mr. Yee while he was on his break. When he attended the unit, he was advised that it was actually a code blue. A code white is activated to address a patient who is being aggressive or violent. A code blue is activated in the case of a medical emergency. After being notified that it was actually a code blue, Mr. Yee informed staff that a crash cart was necessary. He also informed staff that security needed to be contacted to provide further assistance with CPR. As well, he directed that the duty medical officer, the central services manager, and 911 be contacted. All staff on the unit were trained in CPR and were re-certified annually.

Mr. Yee advised that if a patient has been admitted voluntarily, as in Ms. Credgeur's case, unless staff can identify a direct hazard, the patient would have their belongings in their possession. This would include the bag that the possessions arrived in. This was not always the practice. Although Mr. Yee was not certain when the policy changed, patients were previously clothed in pyjamas when they came onto the unit and were not provided with their personal belongings. He cited patient rights as to why the change was made allowing voluntary patients to be provided with their personal belongings.

In addition to the plastic bags that hold patient belongings when they are transferred from another hospital, patients also have access to other plastic bags, such as garbage bags in the hallways. A majority of all patients on Unit 12(a) have suicidal ideation of one type or another. During his eight years working on Unit 12(a) at AHE, Ms. Credgeur's suicide is the only suicide that occurred on the unit.

Viva Voce Evidence of Mark Snaterse:

Prior to Mr. Snaterse testifying, I was advised by Inquiry Counsel that after Ms. Credgeur's death, AHS conducted a quality assurance review. However, we do not have access to the findings arising out of that review, given that it is privileged under s. 9 of the *Alberta Evidence Act*.

At the time of the Inquiry, Mr. Snaterse was employed by AHS as the Executive Director for Addiction and Mental Health for the Edmonton Zone and had held that position for 12 years. In that role, he oversees all of the addiction and mental health programs in Edmonton. AHE is part of that portfolio. In the city of Edmonton, mental health beds are located in five hospitals. There are a total of 288 acute mental health beds, 120 of which are located at AHE. Unit 12(a) at AHE is described as a referral unit. If an admission is to be made to that unit, a referral is made by the psychiatrist in the emergency department who wishes to admit a patient. The unit at AHE must accept the referral before a patient may be transferred to the unit. The total number of beds at AHE is 295. The hospital generally operates at 100 percent capacity; there are rarely empty beds.

A significant portion of the evidence of Mr. Snaterse replicated the evidence of Mr. Yee regarding the scheduling and training of nursing and other staff on Unit 12(a). For that reason, that evidence will not be summarized here.

Since AHS was created, there has been a direction to ensure that policies are provincial in nature; so that the standard practice is the same whether a patient is admitted in Edmonton, Red Deer, or Calgary, for instance.

Unit 12(a) does not have video monitoring. However, emergency departments have some video monitoring, particularly in the mental health areas. Mr. Snaterse testified that the evidence is fairly weak to support video monitoring being an effective deterrent for any kind of behaviour. The evidence is clear that the environment that people receive their treatment in needs to be welcoming. Structures that are put in place that give the environment the feeling of a correctional institution increases agitation and thoughts of self-harm. This is the reason why there are few areas in Edmonton that have video monitoring. The existence of video monitoring also provides somewhat of a false sense of security to staff, so that staff may at times not be as diligent in their observations. Everything on a mental health unit is designed to be as safe as possible while still creating a warm, therapeutic environment. Generally, on a mental health unit, the negative consequences of the existence of video monitoring outweigh any possible benefits.

Every time there is a tragedy such as Ms. Credgeur's death, there is an internal review that takes place. It may be an informal review or it may be a highly structured review called a quality assurance review. A quality assurance review was conducted following Ms. Credgeur's death. There were four recommendations that were made as a result of that review.

1. Examine all technologies to determine if there is something that could assist with observations made of patients at night. The human ability to observe is heavily relied upon. The determination was made that there is no technology that could be used to assist with observations on a mental health unit. The technology that exists requires patients be hooked up to monitors. This would not be practical or helpful on a mental health unit.

2. Add formal training for staff during their orientation regarding searching patient belongings when they first come onto the unit.

3. Advise patients that throughout the night, staff will be checking in on them regularly. Inform patients that staff do not want to be constantly waking them up, but staff have a duty to ensure their well-being. Patients are to be informed of their observation level.

4. When a patient is first admitted to the unit, all efforts will be made to place them in a bed where observation can be done in the least intrusive manner.

In AHS, there is a strategic clinical network for addiction and mental health. Their role is to be up to date on current literature and current technology. Following Ms. Credgeur's death, Mr. Snaterse requested that this group examine whether there were current innovative technologies that could assist with observations of patients. Unfortunately, it was determined that there were none available.

The room that Ms. Credgeur occupied, Room 2, was in the middle of the unit and was a double room. Recommendation 4 suggests that, where possible, a newly admitted patient be placed in a single room close to the nursing station, where observations can be done in a less intrusive manner. Placing a patient in a single room also makes the observation of breathing easier. Breathing sounds are more easily monitored if there is only one patient in the room.

Mr. Snaterse testified that all of the required information regarding Ms. Credgeur was provided by RAH when she was transferred to AHE. He described the orders received from RAH as robust. Shortly after arriving on the unit, Ms. Credgeur's treating psychiatrist, Dr. Abdullah, was able to assess her and validate all orders from RAH, including medications, observation levels, and passes and privileges.

Mr. Snaterse spoke about the policy regarding personal possessions when a patient arrives at AHE. There is a balance between respecting a patient's rights and ensuring they are safe. Searching of personal belongings is to be done in a way that is respectful but also appropriate. It is to be done in a way that respects the rights, dignity, autonomy, and consent of patients whenever possible. Searching is to be done in the least intrusive way possible. Some patients are allowed to keep many of their belongings, other patients are allowed to keep very few. Mr. Snaterse noted that one can harm themself with almost anything. It is therefore impossible to have an in-patient unit that is completely free of all risks. In Mr. Snaterse's opinion, the plastic bag holding the personal belongings of a patient would not be withheld. He indicated that it is no more dangerous than a pair of socks or a pillowcase, for instance.

A comprehensive environmental risk assessment is completed on each unit every two years. It includes the examination of such things as points of ligature, doorknobs, towel bars, chipping paint, fraying carpets, the amount of weight the curtain rods hold, and sightlines. Anything that could be a risk to a patient is examined.

Suicide risk is extremely dynamic. It can change from day to day, and sometimes from minute to minute. There is a policy entitled Suicide Risk Screening, Assessment, and Safety Planning. Staff assists each patient with developing a safety plan if they are experiencing thoughts of self-harm. They discuss who the patient can talk to, what supports are available, and what positive things exist in their life that make their life worth living. Ms. Credgeur completed a safety plan while she was at RAH. The safety plan follows the patient if they are transferred and often evolves over time.

Ms. Credgeur was seen by three psychiatrists and a senior resident psychiatrist in the 48 hours prior to her death. Comprehensive assessments were completed by each of these doctors regarding Ms. Credgeur's suicide risk, although Mr. Snaterse noted that imminent suicide risk is very difficult to predict. None of the psychiatrists who interacted with Ms. Credgeur in the 48 hours prior to her death felt that she met the criteria for certification under the *Mental Health Act* as being an acute risk of harm. Mr. Snaterse is of the opinion that proper mental health/suicide risk assessments were completed by both RAH and AHE with respect to Ms. Credgeur. All patients are assessed in the same way for suicide risk whether they are voluntary or involuntary (also known as formal and certified).

Again, Mr. Snaterse described the determination of the level of observation to be a careful balance between safety and maintaining the carefully constructed therapeutic environment of the unit. The default level of observation for a new patient is every 15 minutes. If the nursing staff are of the opinion that a higher level of observation is required (the only higher level being constant observation), they may contact a doctor to make that order. All observations that are done are under the direction, supervision, and accountability of the charge nurse on duty. When observations of patients are taking place at night, nurses or psychiatric aides must hear and visualize a minimum of three respirations. As sleep is an important part of recovery, the individuals performing observations must balance the need for safety with the need for sleep. They do so by making observations in the least intrusive way while ensuring safety.

There are two gaps in the notations of the observations of Ms. Credgeur while at AHE. One occurred at 2350 hours on June 21, 2018, the other at 0645 hours on June 22, 2018. It was explained that the observations are not always done spot on. This is in recognition of there being 20 beds in the unit. As well, there are often disruptions that occur that would mean the observations may not occur at exactly the 15-minute mark. It is not uncommon to see blanks in the notations of observations during the night in an acute in-patient mental health unit.

In the twelve years that Mr. Snaterse has occupied this role, there have been three suicides that have occurred on an in-patient unit. The suicide of Ms. Credgeur is the only one involving the use of a plastic bag. On an almost daily basis, staff are involved in preventing suicide attempts.

Recommendations for the prevention of similar deaths:

Having regard to the facts of this tragedy as disclosed in this Inquiry, through both viva voce and documentary evidence, and the submissions of Counsel, the following recommendations are made:

1. Although it is impossible to remove all items that are capable of assisting with self-harm, when a patient is admitted to AHE, whether voluntarily or involuntarily, if their belongings are contained in a plastic bag, that bag should be immediately and permanently removed from their possession.

2. Observations of patients should occur as directed, regardless of an emergency occurring elsewhere or a shift change occurring.

3. In order to facilitate observations occurring as scheduled without exception, more staff are required on the units at AHE, specifically at night. There should always be at least two nurses or psychiatric aides responsible for observations at any given time. The intended result is that observations would occur as directed, rather than at times 5-10 minutes beyond when they were ordered to occur. This would also encourage very careful, diligent observations, rather than having to rush through to meet the time requirements.

4. All nurses and psychiatric aides employed at AHE should have ongoing training as to how to conduct the scheduled observations of patients. This training should include specific training regarding the observation of respiration and should occur, at minimum, annually.

5. A thorough review of all available technology that may assist in completing observations should be conducted at least every six months. This frequency is necessary as the advances in technology are ever evolving.

6. All newly admitted patients should be placed in a single room.

7. All newly admitted patients should be placed in a room close to the nurses' station and with good sightlines from the nurses' station.

DATED September 5, 2023,

at Edmonton, Alberta.

"Original Signed"

Carrie J. Sharpe
A Justice of the Alberta Court of Justice