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 Provincial Court 323 - 6 Avenue S.E.

in the City (City, Town, Village) of Calgary (Name of City, Town, Village)

on the 22nd day of June, 2000 (year), (and by

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

before William R. Pepler, a Provincial Court Judge.

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

of Rodney Edgar GAUTIER (Name in Full) 31 (Age)

of #3, 10033 - 81 Avenue Edmonton, Alberta (Residence) and the following findings were made:

Date and Time of Death: October 4, 1999 Between 2:30 and 7:14 a.m.

Place: Calgary Remand Centre 12200 - 89 St. N.W., Calgary, 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)).

Cardiac Arrhythmia

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)).

Natural

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Circumstances under which Death occured:

See attached

No. of additional pages attatched 1 1/2

Recommendations for the prevention of similar deaths:

See attached

No. of additional pages attatched 1

DATED this 19th day

of July, 2000
year

A Judge of the Provincial Court of Alberta

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

Mr. Gautier was transferred, in custody for a minor offence, from Edmonton to Calgary on Friday, October 1, 1999. He informed the admitting nurse of his medical history and advised that he had been vomiting overnight. He was subsequently transferred to the Health Unit at the Calgary Remand Centre. There, he reported on Saturday that he had abdominal pain, had not had a bowel movement for two days and was still vomiting. His vital signs were and remained stable. On Sunday, October 3 he was given both a suppository and a Fleet enema with little result. He vomited once on Sunday but continued to take fluids. He received Metamucil, Maalox and Gravol while in the Health Unit.

He called for and saw the nurse at 11:30 p.m. on Sunday, October 3rd and again at 2:20 a.m. on Monday, October 4th. At 2:30 Mr. Gautier reported to be feeling better but having some pain when he moved and some shortness of breath.

Two nurses, who administered to Mr. Gautier and gave evidence at this Inquiry, thought he should see the doctor on Monday but neither nurse was of the belief that the doctor should be called or that Mr. Gautier should be sent to hospital. Both nurses in cross-examination stated they didn't know that he had been vomiting for three days and if they had known that they would have observed him more closely or perhaps contacted a physician.

Dr. John Gillespie gave evidence at the Inquiry. He is the consulting physician for the Calgary Remand Centre and has been so appointed for a number of years. His evidence is that he was surprised that he had not been called when he heard that Mr. Gautier had been vomiting for a number of days. He was quick to state however, that he would not second guess the nurses and their judgment in the matter. The doctor gave evidence that shortness of breath may be a sign of acute arrihythmia; and that vomiting would not necessarily be a sign but it could lead to dehydration and electrolyte problems that could affect the functioning of the heart. He suggested that these two symptoms and no bowel movement would probably not call for lab work and that a physician would take a wait and see approach.

Dr. Lloyd Denmark, a forensic pathologist, fixed the cause of death as cardiac arrihythmia. He stated that such a determination was not based on proof as such but on exclusion of other causes. While Mr. Gautier had a number of presenting problems, noted above, these were not the cause of the cardiac arrihythmia and his death was not predictable with a normal pulse. As well, Mr. Gautier had a number of other medical issues including: Hepatitis C, HIV, crystals in the lung from intravenous tablet use and scar tissue from previous surgeries all of which weakened his condition. These conditions were not causal to his death.

The time of death could not be fixed by Dr. Denmark although medical examination pointed to shortly after Mr. Gautier was seen at 2:30 a..m. on October 4. Some confusion arises

because the doctor believed, as noted in his autopsy report, Exhibit 11 of the Inquiry, that the nursing staff had talked with Mr. Gautier at 5:00 a.m. The oral evidence given at the Inquiry is clear and at that hour the nurse simply observed Mr. Gautier through the window and assumed he was sleeping.

Neil Balkham, a correctional officer, did the informal round at 5:40 a.m. and reported in evidence that Mr. Gautier "seemed to be asleep."

Lisa Wallace, a correctional officer, did the formal count at 4:53 a.m. and reports that Mr. Gautier was breathing at that time. This officer also did the formal count at 6:20 a.m. and believed she saw him breathing but is not absolutely sure. She also believes that Mr. Gautier called for the nurse at 4:00 a.m. and that the nurse responded. The nurse does not confirm this meeting but reports that she looked in on Mr. Gautier on her rounds between 4:30 and 5:00 a.m. and reports that he "appeared to be sleeping."

Alister Cripps, a correctional officer, came on duty for the morning shift and did a check of Mr. Gautier's cell at about 6:55 a.m. and assumed he was a low breather. A short time later when Mr. Gautier did not come out for breakfast, Mr. Cripps went to his room and at 7:15 a.m. found Mr. Gautier in the same position he had been in at 6:55 a.m. CPR was initiated and the ambulance was called.

RECOMMENDATIONS:

Evidence given at this Inquiry strongly suggests that a single night nurse may have too many duties. The nurse must attend to existing patients and to new admissions that come in during the night. She/he must familiarize herself/himself with patient records and make his or her own reports.

The recommendation of this Inquiry that a second nurse be added to the night shift has been anticipated by Alberta Justice; and the Department, based on recognized need, has begun the process to add a second nurse to this shift.

It appeared at the Inquiry that nurses were not completely familiar with patient histories recorded on prior admissions and had some difficulty in transferring information from shift to shift. This may be due in part to the fact that note taking is more general than that employed in a hospital setting and that charting is done only once per shift.

It is the recommendation of this Inquiry that a review be made of note taking procedures, patient charting, and the procedures followed for the transferring of information from shift to shift.

The Standard Operating Procedures were revised in December of 1999 by adding the following paragraph:

> "iv) The centre physician is to be consulted regarding offenders suffering from an acute gastro-intestinal disturbance whose symptoms persist beyond twenty-four hours. If the centre physician is unavailable, the offender must be transported to the hospital for further assessment."

This amendment appears to reduce the scope of discretion available to the duty nurse and will ensure that inmates with this affliction will be seen by a physician in a timely way.

In making their rounds the correctional officers must look for signs of life. This is not always an easy task - the night light is very weak and the officers are reluctant to disturb the inmates by using their flashlights or entering cells. This conflict may result, as in this case, with assumptions being made that inmates are sleeping.

It is the recommendation of this Inquiry that such steps be taken as are necessary to ameliorate the difficulty correctional officers have in completing their rounds and determining the state of individuals.

It is the recommendation of this Inquiry that correctional officers' notes be more detailed; including at least, a notation as to which officer completed the particular set of rounds and a further requirement that the notes and reports prepared by one officer be reviewed and approved by any other officer who will necessarily rely on those notes in any further proceedings.