ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts Building

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

on the 21st, 22nd and 23rd days of November, 2017 (year), (and by adjournment

on the 28th day of March, 2018 (year)),

before The Honourable Joyce L. Lester, a Provincial Court Judge,

into the death of Thelma Eileen Williams (Name in Full) 67 yrs (Age)

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

Date and Time of Death: February 1st, 2012 at approximately 10:55 p.m.

Place: Royal Alexandra Hospital, Edmonton, 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)).

Complications of Breast Carcinoma

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

This is a report to the Minister of Justice and Solicitor General in relation to an Inquiry conducted pursuant to the provisions of the *Fatalities Inquiries Act*, RSA 2000, F-9 into the death of Thelma Eileen Williams on February 1, 2012. Mrs. Williams died several days after having breast cancer surgery at the Royal Alexandra Hospital in Edmonton, Alberta.

The evidence was presented by Inquiry Counsel Denise Harwardt and Witold Lipnicki. Four of the physicians who were involved in this matter were represented by Rose Carter. Alberta Health Services was granted standing in this matter and was represented by Brent Windwick. Mrs. Williams' husband Duncan Williams, daughter Rachel Williams, and son Simon Williams were present at the Inquiry, but were unrepresented. They were assisted by Ms. Harwardt during the Inquiry.

The Inquiry spanned four days. The Court heard evidence on the circumstances of Mrs. Williams' death, the examination of her body by the medical examiner, and the patient discharge procedures at the Royal Alexandra Hospital.

Witnesses Presented to the Court

1. Dr. Ann Bucholtz – Medical examiner.
2. Dr. Daniel Schiller – Surgeon (Royal Alexandra Hospital).
3. Dr. Shahzeer Karmali – Medical resident at the time of Mrs. Williams' discharge; evidence read into the record.
4. Dr. Thomas Maguire – Family physician.
5. Bonnah Siemens – Homecare nurse for Mrs. Williams, post-surgery.
6. Dr. Bernard Bannach – Assistant Chief Medical Examiner.
7. Dr. Ni Lam – Emergency physician (Royal Alexandra Hospital).
8. Duncan Williams – Husband of Mrs. Williams.
9. Rachel Williams – Daughter of Mrs. Williams.
10. Simon Williams – Son of Mrs. Williams.
11. Sandra Tisi – Registered nurse and patient care manager (Royal Alexandra Hospital).
12. Michelle Reynes – Registered nurse and transition coordinator with patient care manager (Royal Alexandra Hospital).

Circumstances of the Death

Thelma Eileen Williams was born on July 25, 1944. She passed away at 67 years of age, several days after having breast cancer surgery.

She suffered from multiple sclerosis ("MS") and was first diagnosed with the disease in 1986. Her MS had worsened significantly by the time of her surgery. She had limited mobility and used a wheelchair. Her husband, Duncan Williams, was her primary caregiver and her daughter Rachel would assist from time to time. Mrs. Williams was a stoic person who would rarely complain about her MS or other health issues. Her adult children testified that when they were growing up, they had very little knowledge of their mother's MS. The family had concerns with Mrs. Williams' cognitive abilities. There were concerns that her memory and mental acuity were diminishing. These concerns were also noted by her family doctor, Dr. Maguire, as well as by her neurologist, Dr. Warren, as early as May 2010. Dr. Warren did not testify at the Inquiry; information from the neurologist was present in Dr. Maguire's notes and correspondence which were entered as exhibits. Mrs. Williams' diminished cognitive abilities and limited mobility issues may have complicated her hospital discharge.

On December 29, 2011, Dr. Maguire sent Mrs. Williams for testing of a lump found on her breast. On January 5, she was diagnosed with breast cancer and the medical process for treatment was set in motion. She was referred to Dr. Schiller for surgery to remove the cancerous mass in her right breast; this was the only possible treatment. Dr. Schiller saw her for a consultation on January 12. Dr. Schiller noted that she suffered from MS, that she had mobility issues, and that she would require homecare after the surgery. All surgeries have certain risk factors and Dr. Schiller recognized that Mrs. Williams' having MS would add additional risk. No pre-surgery issues seriously concerned Dr. Schiller. However, the evidence of the family members was that he did not appreciate the true extent of Mrs. Williams' MS and mobility challenges.

The surgery was performed on Friday, January 27. The surgery was successful and there were no immediate issues. Dr. Schiller's treatment plan prescribed an extended stay in the hospital of 4 to 5 days. This treatment plan was not adhered to and the discharge was ordered at least two days earlier than directed. Mrs. Williams was discharged on Sunday, January 29. The formal discharge order was given at 6:00 a.m. and the family was called early Sunday morning to pick up Mrs. Williams. The family had to take Mrs. Williams home in a wheelchair-friendly taxi cab.

It is not clear who ordered the discharge. Dr. Schiller was not working over the weekend; he finished his last shift on Friday, January 27. Evidence was presented that the early discharge was ordered by a surgical resident. The discharge order was noted and logged in the post-surgery patient notes for Mrs. Williams. The order was signed with the letter "R" (or potentially "R1" or "R2"), which indicates that a resident physician authorized the discharge. However, no name is attached to the discharge order. No definitive evidence was presented to identify the resident who issued the discharge order. Evidence from Dr. Karmali, one of the two surgical residents on rotation at the time of Mrs. Williams' discharge, was presented to the Court by way of a letter. The information from Dr. Karmali indicates that it was most likely not him who issued the discharge order. His records indicate that he never billed Alberta Health for medical services for Mrs. Williams and that he did not attend to her. The second resident, who most likely ordered the discharge, was Dr. Al-Shareef (the physician's full name is unknown). Dr. Al-Shareef was not available to testify at this Inquiry as he or she is currently working in Saudi Arabia.

It is unfortunate that the discharge records for Mrs. Williams are not complete. This is a serious oversight in hospital procedures, from that time. The discharge of Mrs. Williams was only documented by a medical resident's markings. No further signature identification or note in an electronic information management system was required or possible. This does not permit adequate review of treatment orders, by a hospital oversight body and by this Inquiry. The early discharge of Mrs. Williams was highly problematic. There was a substantial lack of communication amongst Dr. Schiller, the resident who ordered the discharge, the nursing staff, and the family.

The procedure in January 2012 was for surgeons to prescribe their patients post-surgery treatment plans, including the length of stay in the hospital for recovery. If or when surgeons left the hospital and were no longer on call, they were to "sign out" their patients to the next doctor. The sign-out process was to provide written communication by way of notes regarding treatment plans and anticipated discharge dates. The ultimate decision on discharge and treatment then rests with the physician taking over. Further consultation with the original surgeon is limited.

A key concern in this case is that the relief physician did not have all of the information necessary to provide optimal patient care at the time of discharge. Dr. Schiller and the resident who took over for him had no verbal communication or further consultation about Mrs. Williams or her early discharge. It is not clear whether the resident physician had all the information regarding Mrs. Williams' limited mobility and severe MS condition. However, Dr. Schiller testified that, in and of itself, an early discharge in this case may not have been particularly concerning; the early discharge of Mrs. Williams was not necessarily an error.

Dr. Schiller testified that he spoke with the chief resident who ordered the discharge after these events unfolded. The discussion indicated that the chief resident was surprised that Mrs. Williams passed away. According to Dr. Schiller's testimony, Mrs. Williams acquiesced to the discharge. She was "okay" with being sent home. The evidence indicates that there was some reliance on Mrs. Williams' consent to the discharge. This is a further area of concern.

It is normal for a patient to wish to leave the hospital and go home to recover. A patient's wishes in this regard may not always be inappropriate. In this case, however, Mrs. Williams' surgery was recent (two days prior), her cognitive abilities were in question, and her age and debilitating disease presented challenges to her recovery. Her stoic demeanor would have ensured that she would not protest this decision. In the case of a vulnerable patient, which does describe Mrs. Williams, any acquiescence to a discharge order must be taken with great caution. Especially if this acquiescence is given without any additional conversation with other family members.

A final area of concern around the discharge centers on the family's interaction with the nursing staff. Duncan and Rachel Williams attended the hospital to pick up Mrs. Williams. They had serious concerns with the early discharge; they had been informed that Mrs. Williams would remain in the hospital for several more days. They attempted to challenge the discharge and requested to speak to the physician who ordered it. The hospital staff did not accommodate or discuss any concerns regarding the early discharge and informed the family that the doctor was not available to discuss the decision. Mrs. Williams was confused and not alert at that time. She was also nauseous and still feeling unwell.

The family was very aware of the limitations Mrs. Williams faced. Their concerns should have been addressed and better communication between the family and the nursing staff was necessary. There were no procedures at the time to address family concerns at the moment of discharge. The discharge decision was essentially made unilaterally by the attending physician. This procedure alienates the family. The discharge procedure, particularly for vulnerable and disabled patients, was inappropriate and placed patients at risk of not receiving adequate care. A discharge procedure that emphasizes communication and joint decision making would significantly benefit vulnerable patients.

Mrs. Williams arrived home from the hospital on the morning of Sunday January 29. A homecare nurse, Bonnah Siemens, was assigned to Mrs. Williams when she was discharged from the hospital. Ms. Siemens was to attend to Mrs. Williams and assist with medical needs while she was recovering at her home. Ms. Siemens first reached out to the Williams family by phone and then attended to the family in person on Monday, January 30. She attended in person to Mrs. Williams several times over the course of two days, Monday January 30 and Tuesday January 31.

Mrs. Williams' health was progressively deteriorating. She was in pain, nauseous, and constipated. Ms. Siemens found her dehydrated on each visit. These symptoms continued to get worse in the two to three days that she was at home following the surgery. Dr. Maguire went to visit Mrs. Williams at home on January 31 and noted that she was not recovering well from surgery. The next day, Ms. Siemens called Dr. Maguire to consult with him about Mrs. Williams' condition. Mrs. Williams' constipation was the most concerning health issue. After the phone consultation, the decision was made to send Mrs. Williams back to the hospital. Emergency medical services arrived around 2:10 p.m. on Wednesday, February 1, and took her to the emergency room ("ER") at the Royal Alexandra Hospital in an ambulance.

Mrs. Williams arrived at the ER around 3:15 p.m. The triage nurse assessed Mrs. Williams and ranked her as a '3' on the emergency scale, meaning that there are concerns with the patient, but no issues that require immediate attention. After approximately three hours, around 6:30 to 7:00 p.m., she was seen by Dr. Lam.

Dr. Lam's initial diagnosis identified some problems with Mrs. Williams' abdomen. Very shortly after Dr. Lam completed her initial diagnosis, just as she was leaving the room, Mrs. Williams had a severe seizure. She then proceeded to cardiac arrest. Mrs. Williams was intubated and various resuscitation methods were employed. The ER physicians were able to resuscitate her. At this point she was on life support. Mrs. Williams was being treated with respiratory support and medication to maintain her heart rate and blood pressure. She was deteriorating very rapidly.

Dr. Lam proceeded to discuss options going forward with the immediate family; Mr. Williams, Ms. Rachel Williams, and Mr. Simon Williams. Mrs. Williams' chances of recovery were minimal at this point. The family decided to take Mrs. Williams off life support and let her pass away peacefully. They were by her side when life support ended. Mrs. Williams died at approximately 10:55 p.m. on February 1, 2012.

Dr. Bannach, the Assistant Chief Medical Examiner, gave evidence of the process that the office of the Chief Medical Examiner follows in a death investigation. The office of the Chief Medical Examiner is notified of any death that occurs within 10 days of a surgery. If the case is accepted for investigation, a medical investigator first attends to the body. The medical investigator creates an Investigator's Report of Death, and makes a determination as to whether the office of the Chief Medical Examiner must be further involved. Non-natural death and natural deaths that are sudden and unexpected are investigated by a medical examiner. The medical examiner determines the manner of death, medical cause of death, and, possibly, mechanism of death after performing an autopsy or an external examination of the body. The manner and cause of death are given to Vital Statistics for record processing and end up on the death certificate. The manner of death is a statistical label and has six possible classifications: natural, accident, suicide, homicide, undetermined, and unclassified. The cause of death is a medical or pathological determination and is more "general" in nature. A medical examiner may also make determinations as to the mechanism of death. The mechanism of death is the physiological process that leads to death; it informs how the medical examiner decided the cause of death. (For example, someone who was stabbed to death could have "knife wound" as the cause of death and "loss of blood" as the mechanism of death.) Autopsies are not automatically performed; the medical examiner has discretion and may not initiate autopsies in cases where the manner and cause of death are obvious. Part of the autopsy process is a discussion with the family to determine whether they would like an autopsy performed. The family's wishes are given serious weight, and often religious considerations need to be respected. However, the medical examiner is the ultimate decision-maker when it comes to performing an autopsy.

The autopsy discussion with Mrs. Williams' family had serious issues. The medical examiner's office was informed that the family did *not* want an autopsy performed. This information was communicated with the medical examiner through the Investigator's Report of Death. Dr. Lam testified that she had no recollection of having a conversation with the family about the autopsy and could not testify as to who spoke to them about it. The family all testified that Dr. Lam discussed the autopsy with them, although they were not sure whether Dr. Lam asked them if they would like an autopsy performed or simply informed them that an autopsy would not be performed. The family's decision on an autopsy is important and the decision is taken into consideration by the medical examiner. The family should have an opportunity to make a fully informed decision. They should be given information about the consequences of not having an autopsy performed. The fact that the ultimate decision remained with the medical examiner, regardless of the family's wishes, should have been explained to the family.

In this case, each family member testified that the discussion of the autopsy took place at the same time as the discussion regarding Mrs. Williams' withdrawal of life support, while Mrs. Williams was still alive. This is highly problematic. Consideration of an autopsy should not take place while a patient is still on life support, nor right after a patient passes away. Families should be given some time to grieve and process the death of a loved one before the discussion about an autopsy is initiated. The communication between the family members and Dr. Lam regarding the autopsy had serious deficiencies. Had this conversation been more thorough and compassionately handled, the family could have made a reasonably informed choice.

Mrs. Williams' body was taken to the medical examiner's office for investigation. This was a sudden death in a hospital and fell within their jurisdiction. The manner of death was classified as natural and the medical cause of death was classified as complications of breast carcinoma. A further conclusion was added to the death certificate; under the heading significant condition contributing to death, multiple sclerosis was listed. An external examination was performed; however, no autopsy was done. This was the decision of the medical examiner, Dr. Bucholtz. To come to this decision, she factored in the family's wishes (which were erroneously communicated), Mrs. Williams' medical history, and the incident which preceded her death. Dr. Bucholtz considered that there was nothing particularly alarming or unique about this death which would require an autopsy. The mechanism of death remains unknown. The theory put forward by Dr. Lam is that Mrs. Williams suffered a pulmonary embolism and a hypo-seizure which ultimately led to her death. However, this will remain unknown because an autopsy was not performed.

Dr. Bucholtz's decision not to perform an autopsy will not be assessed here. That was a decision within the professional discretion of a medical examiner. There are circumstances where an autopsy is not necessary and an external examination is sufficient. Whether or not this is such a circumstance is beyond the scope of this Inquiry. The purpose of this Inquiry is not to determine liability or fault, but rather to make recommendations to prevent future deaths. The central problem with the autopsy was the lack of discussion between the family members and the ER physician. Better communication would have ensured that the family and the office of the Chief Medical Examiner both would have been able to make decisions with accurate and complete information.

Recommendations for the prevention of similar deaths:

The death of Mrs. Williams is a tragic occurrence. Certain questions relating to the circumstances surrounding her death remain unanswered. It is not the purpose of this Inquiry to find fault. No one can state for certain what would have resulted had Mrs. Williams remained in the hospital for a longer period of time. Better communication is the theme of this report. Robust communication procedures for all health care members – from the nursing staff to the doctors – are required to ensure that vulnerable patients, particularly, are appropriately cared for and a similar situation does not occur in the future.

1. **A better communication procedure must be in place when hospital physicians "sign out" or transfer patients to the relief physician when their shifts end.** This is particularly necessary for disabled patients. This is crucial for sign-outs that occur during the weekend as health care resources are not as available during those times.

   This recommendation is necessary to ensure that the primary physician, the one who performed the surgery and has the medical history of the patient available, is able to communicate care instructions to the relief physician.

   Dr. Schiller addressed this specific point in his testimony. The sign-out process now involves face-to-face or telephone communication where individual patient care is discussed between the primary and relief physicians. Further, there are now three on-call surgeons at the Royal Alexandra Hospital over the weekend, whereas in 2012 there were only two. The increase in the number of on-call surgeons provides for more points of contact and consultation on the discharge of vulnerable patients. This recommendation has largely been addressed.

2. **An adequate communication procedure that addresses communication among hospital staff as well as between families and hospital staff must be in place for the discharge of patients.** This procedure must give families an opportunity to address concerns regarding the discharge and must be in place for discharges that occur over the weekend. In general, since there are less heath care resources and hospital staff available over the weekend, disabled patients are particularly vulnerable if discharged during this time.

   This recommendation is necessary to ensure that the physician ordering the discharge is able to engage in a dialogue with concerned family members and hospital staff regarding that decision. Further, this procedure will allow family members to voice concerns and request additional support. The lack of communication and care at the discharge phase was apparent in the case of Mrs. Williams. Not only were family concerns left unaddressed, Mrs. Williams had to go home in a taxi and also did not receive homecare the day of her discharge. These are significant issues for an elderly, non-ambulatory patient that should have been addressed by the hospital.

Two patient care managers at the Royal Alexandra Hospital, Sandra Tisi and Michelle Reynes, testified to new policies at the hospital which have largely addressed these concerns. The hospital implemented a new policy called 'Co-Act' in 2014. Patients can now designate a primary support person who will advocate and communicate with hospital staff on their behalf. The nursing team and the family member can now voice concerns regarding a discharge directly to the physician. A full assessment will be done prior to discharge. Two new information databases are in place to ensure that hospital staff have all the relevant information available. The hospital no longer relies as heavily on written notes and verbal communications. There is also a transition coordinator position that connects patients' family with community services, such as homecare. The evidence presented at the Inquiry largely demonstrates a cultural shift at the Royal Alexandra Hospital that now emphasizes communication between patients, their family members, and the hospital staff.

3. **A communication procedure regarding the autopsy decision must be in place between family members and ER physicians.** Discussions with family members about autopsies should not be conducted in combination with other sensitive topics, such as the withdrawal of life support. Discussions regarding autopsies should not take place immediately after a patient dies; the family should be given some time to grieve and process the death before making such an important decision.

   An autopsy does not directly prevent future deaths. However, an autopsy can be informative. Autopsies can provide further information to improve health care practices for the future, and may also provide a level of comfort and understanding to those family members left behind. There can never be too much compassion when loved ones are dealing with the loss of a family member.

   Evidence was presented from the office of the Chief Medical Examiner on how the family's wishes are now addressed. A medical examiner will attempt to honour the family's wishes when possible. A medical examiner might confirm family wishes, either through the medical investigator or by contacting the family directly. These changes ensure that the medical examiner has accurate information. No evidence was presented that discussed how ER physicians address the autopsy with the family. The Royal Alexandra Hospital should have a uniform process in place for physicians to rely on when they address autopsies. There should be a standard practice for the discussion of autopsies with the patient's family so that the family is able to take a fully informed position.

DATED January 15th, 2019,

at Edmonton, Alberta.

Original signed

The Honourable J.L. Lester
A Judge of the Provincial Court of Alberta