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 the Courthouse

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

on the 13th to 17th days of June 2016 (year), (and by adjournment

on the 20th to 24th days of June, 2016 (year)),

before Hon. B.D. Rosborough, a Provincial Court Judge,

into the death of Valerie Wolski (Name in Full) 41 (Age)

of Site 1, Comp 8, P.O. Box 8, RR2, Camrose, Alberta (Residence) and the following findings were made:

Date and Time of Death: Found dead on February 13, 2011 at 9:00 a.m.

Place: A, 5412 – 51 Avenue, Camrose, 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)).

Manual Strangulation.

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Homicide.

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

Summary

Sometime between February 12th, 2011 at 5:00 p.m. and February 13th, 2011 at 8:55 a.m. Terrence Wade Saddleback ('Saddleback') strangled Valerie Wolski ('Wolski') to death. Saddleback was a young man suffering from severe developmental and behavioral disorders. Wolski was employed as an Individual Supports Worker with the Canadian Mental Health Association – Alberta East Central Region 2000 ('CMHA'). The death occurred at a community-based residence in Camrose, Alberta at a time when Wolski had been assigned exclusive responsibility for Saddleback's care.

Terrence Wade Saddleback

Saddleback was born to Elaine Saddleback in Calgary, Alberta on April 11th, 1985. He resided with his mother on the Samson First Nation in Maskwacis (then Hobbema) until 1990. Thereafter he resided at foster, group or childrens' homes in Bluffton (1990-93), Ponoka (1993-95) and Wetaskiwin (1995-2008). The Wetaskiwin and District Association for Community Services ('WDACS') provided support for Saddleback commencing in 1993 and continued to do so until the summer of 2009. At some point in that continuum it was determined that Saddleback could no longer reside in the community. He was placed in supervised settings by WDACS with support from the Ministry of Human Services, Persons With Developmental Disabilities ('PDD') (from 1997 onward). This continued until 2009 when WDACS declined to provide any further caregiving services to Saddleback.

Saddleback was admitted to the Centennial Centre for Mental Health and Brain Injury ('CCMHBI') on several occasions. On July 9th, 2009 he was admitted and remained in that facility until his discharge in December of 2010. It was at that time that an agreement was entered into between CMHA and PDD to house Saddleback in a residence located in Camrose at A, 5412 – 51 Avenue. A caregiver was to be in attendance at the residence 24 hours each day. On February 13th, 2011, following the death of Wolski, Saddleback was recommitted to CCMHBI. He was charged with the offence of manslaughter and, on March 2nd, 2011 was found 'unfit to stand trial' (s.2 C.C.). He was thereafter remanded to Alberta Hospital (Edmonton) where his continued detention and care would be dealt with by the Review Board (s.672.47 C.C.).

Saddleback was diagnosed from an early age with a pervasive developmental disorder with moderate to severe mental retardation. These conditions, said to be permanent and irreversible, were escorted by a disruptive behavior disorder. Reference has been made to these conditions satisfying the definition of a 'dual diagnosis' requiring caregivers to meet 'complex service needs'.

In March of 2011 Saddleback was examined by Dr. C. Green, a forensic psychiatrist at Alberta Hospital in Edmonton. He concluded that Saddleback, " … is extremely low functioning. He can give no adequate account of himself. He requires supervision and prompting with his day-to-day activities and basic care." Dr. Green found Saddleback unable to have any reasonable in-depth conversation with him about any subject, including his understanding of the charge of manslaughter alleged against him or the meaning of a 'not guilty' or 'guilty' plea. "He is completely incapable of instructing his legal advisors. He would not be able to follow court proceedings." For these reasons, Dr. Green was of the opinion that Saddleback was unfit to plead or stand trial and that, "Mr. Saddleback continues to require secure psychiatric in-patient treatment and management." [emphasis added]

Saddleback's History of Anti-social Behaviour & Aggression

Before making reference to Saddleback's history of anti-social and aggressive behaviour, it is important to make reference to his physical attributes. Saddleback is an unusually large man. He stands approximately 6 feet 5 inches tall and is estimated to weigh between 250 and 300 pounds. Precisely when he achieved that stature is not clear on the evidence heard at this inquiry. He was certainly that height and weight well before having been placed in Wolski's care. Aggression exhibited by a man of this stature, even minor aggression, is likely to be far more significant than aggression exhibited by a person of smaller stature. And methods of controlling or responding to aggressive acts by an individual of Saddleback's stature must be adjusted accordingly.

Little evidence was heard at this fatality inquiry about acts of aggression by Saddleback prior to his adolescence. In June of 2005 PDD prepared a report entitled "Brief Consultation Report". Appendix 1 of that report is a document entitled 'PDT' ('Personal Development Team') File Review/History relating to PDD's involvement with Saddleback. The author of that report notes that in 1999 there was a "significant increase in [Saddleback's] aggressive/destructive behaviour". In December of 1999 there was an, "incident of tantrum/aggression". And in January of 2000 there were, "some severe incidents of aggression." The report proceeds to catalogue incidents of aggression in September 2002 ("assaulted staff; assaulted roommate"), July 2004 ("increasing aggression") and March of 2005 ("aggression", "pulling others hair", "verbalizing aggression").

In addition to aggression, this report noted that, in January of 2003, Saddleback had begun "masturbating a lot" and police were involved in incidents involving "inappropriate touching of females". By March of 2005, concerns had arisen with respect to Saddleback eating feces, "touching females – adults on bottom, children on genitals", masturbating excessively (and beginning to do so in public), sexually fondling dogs and "throwing things".

In August of 2000, Saddleback was referred to Dr. L. Caffaro (child psychiatrist). Dr. Caffaro notes the following in his letter of August 15th, 2000:

> Presenting concerns include a history of aggression and mood swings. Terrance went through a period six months ago where his behavior was quite volatile. He would throw chairs through windows. He ran away and had to be brought back by the RCMP and was physically aggressive towards the staff. It would appear that these incidents were triggered by altercations with another female resident in the group home who has since moved out. Apparently after she left, there was one other instance of aggression but his behavior has settled considerably since then.

On July 10th, 2004 Saddleback was involuntarily committed to CCMHBI for "psychotic behavior" and aggression directed toward his caregivers. He was discharged on July 22nd, 2004 but recommitted on August 1st, 2004 appearing quite paranoid ("hallucinating of monsters in the house"), hostile and upon reports of "violent behavior to caregivers". On April 29th/30th, 2005, Saddleback was again committed to CCMHBI because of his aberrant behavior and his caregiver's fears of physical aggression.

On July 11th, 2006 a staff member at WDACS had to lock himself in his bedroom to avoid being attacked by Saddleback. This, after the staff member had redirected Saddleback from leaving his bedroom. Saddleback later broke a window and 2 flower pots at the residence.

On September 11th, 2006 Saddleback began hitting and kicking staff at WDACS when he was redirected. Saddleback grabbed a chair and ran outside and staff had to hold the chair until police arrived. Saddleback was taken to hospital but returned after having been medicated.

On August 25th, 2007 Saddleback ran up to a caregiver and began pulling his hair with 2 hands.

When a female associate intervened, Saddleback grabbed her hair and pulled it forcibly. The female caregiver's head was bruised and her glasses badly bent.

In November of 2007, Saddleback had been placed in the home of Phil and Loretta Johnson. On November 21st, 2007 Johnson's 17 year old, 6 foot 1 inch son, Jay, was vacuuming a room in the house with Saddleback present. For no reason, Saddleback began glaring at Jay Johnson and then forcibly grabbed his hair with both hands. Jay Johnson was able to physically subdue Saddleback and called for help. Phil Johnson arrived and succeeded in de-escalating the situation by administering medication (a 'PRN').

On May 1, 2008 Saddleback became involved in an argument with Phil Johnson over unwanted hugging incidents. When Saddleback is approached by Mr. Johnson, Saddleback grabs his hair on both sides of his head and forcible pulls out some of Mr. Johnson's hair. A physical altercation ensues ending only when a PRN is administered and Saddleback is diverted.

On May 27th, 2008 a caregiver with WDACS reported an incident where Saddleback slapped him aggressively on the back. The caregiver ultimately entered a car only to be hit by Saddleback through the open window. The caregiver drove away and stopped for Saddleback to catch up. When he did so, the behavior repeated itself. A PRN was administered.

Additional incidents of aggressive back-slapping and/or hair-pulling occurred on June 12th, June 17th and June 19th, 2008. On this latter occasion, in addition to pulling the caregiver's hair, Saddleback began kicking and hitting him as hard as he could. The caregiver eventually wrestled Saddleback to the ground and had another call 911 and WDACS. Police arrived and both the caregiver and Saddleback were taken to the hospital. A PRN was administered.

On June 19th, 2008 Saddleback was involuntarily committed to CCMHBI for "unpredictable and violent behavior". It was reported that Saddleback's behavior, " … has been escalating over the last 2 months. He has been quite unpredictable, aggressive and violent especially toward caregivers." CCMHBI records disclose that by that date, Saddleback, "[h]as been in this hospital three times. The last time he was discharged was in May 2006. Again, almost with the similar aggression outbursts."

Saddleback was eventually discharged from CCMHBI to WDACS on April 1st, 2009. Dr. Campbell made note on the Discharge Summary that Saddleback's only problems whilst in CCMHBI were his, " … tendency to pull the hair of female staff and occasional fondling of himself if children were in his immediate vicinity." Saddleback was also noted to be impulsive and intimidating to female patients.

On July 9th, 2009 Saddleback met a female staff member entering a room on the premises. After exchanging greetings, Saddleback immediately grabbed her hair and wouldn't let go. Other residents of the home had to be secured in another room while 3 male staff members came to the assistance of the female staff member. There is a report that Saddleback was in a rage; that he had picked up a female staff member and threw her over a table. After 15 minutes, Saddleback released the staff member's hair but continued trying to kick other staff members. Police were called. A total of 5 RCMP officers were required to subdue Saddleback. Pepper spray and handcuffs were employed.

Saddleback was readmitted to the CCMHBI.

The Executive Director of WDACS reviewed this incident and met with her staff. Of 50 employees, only 2 were comfortable thereafter working with Saddleback. Accordingly, and by letter dated November 19th, 2009 the Executive Director of WDACS advised PDD that her organization was forced to make, " … the difficult decision of having to terminate services for

Terrence Saddleback." The rationale behind this decision was expressed in these terms:

> As you well know, Terrence's high-risk behavior, which has been described as psychotic in nature, is a real threat to himself, staff, clients and community. We do not have the resources to adequately address his needs. During the last critical incident, 5 RCMP officers, pepper spray and handcuffs were required to diffuse the situation. Despite having an effective response time with our RCMP, we do not have the manpower or skills necessary to mitigate risk prior to their arrival. Further, to adapt a home within the community to ensure staff and client safety would be to disregard CET ['Creating Excellence Together'] standards. As well, supporting Terrence in a restricted environment does not fit within our mandate.

Saddleback remained at the CCMHBI until December of 2010; a period of approximately 17 months.

The incidents recounted above were all recorded in written materials secured from WDACS, PDD and CCMHBI and presented at this fatality inquiry. Many were formally recorded in documents styled 'Incident Reports'. In addition to these materials, Inquiry Counsel elicited information from witnesses at CCMHBI relating to more minor incidents appearing in 'Multidisciplinary Notes' recorded by staff at CCMHBI during Saddleback's admissions. They more than substantiate Dr. Campbell's later reference to impulsive, intimidating, assaultive and sexually inappropriate behavior by Saddleback while resident at CCMHBI.

Following his 17 month stay at CCMHBI, Saddleback was transferred to CMHA's residence in Camrose, Alberta. It was there that he killed Wolski. He had been in attendance at that residence for approximately 2 months.

Caring for the Developmentally Disabled

There was an underlying theme permeating this fatality inquiry. It played a role in the placement of Saddleback with CMHA in December of 2010. That theme was the election by the Government of Alberta to move from an institutional model for the care of the developmentally disabled to a community-based model. The full contours of each model, including their respective merits or demerits are beyond the ambit of this fatality inquiry. Nevertheless, it was clear from the evidence of the many professionals testifying at this fatality inquiry that Alberta's transition from an institutional model to a community-based model was not a smooth one (and may remain problematic).

The essential problem confronting those responsible for this transition was that a small group of individuals with complex needs could not be accommodated safely or efficiently in existing community-based facilities. The President of the Alberta Psychiatric Association, Medical Director for Mental Health Services (David Thompson Health Region) and treating physician at CCMHBI, Dr. Douglas Urness, estimated that there were a significant number of these individuals in Alberta, perhaps as many as 50. Without an institutional facility of some sort, agencies such as PDD could not find community-based facilities to house those individuals.

This sentiment was expressed in correspondence to the Minister of Seniors and Community Supports. One such letter from Dr. Urness dated January 31st, 2007 summarizes the difficulty in the following terms:

> Our facility commonly provides services to mentally handicapped individuals who receive services though the PDD Program. A common frustrating issue in managing these individuals is the difficulty in finding accommodation and associated supports outside the hospital when an individual is ready for discharge. Often these individuals have exhausted a wide range of well planned community supports and need a level of care that requires round the clock staffing, a stable and secure physical environment, and an environment or local community which is therapeutic in nature. Historically Michener Centre has been a

> resource for these individuals. Placement in Michener Centre has been a resource for these individuals. Placement in Michener Centre may allow for a further period of stabilization and discharge planning. There is, however, a population of very high need people who require an institutional type of setting in which to live and have a reasonable quality of life.

Briefing materials and responses by Government of Alberta Ministers and their staff acknowledge that the manner of discharge of some individuals with a 'dual diagnosis' from the CCMHBI was a significant issue. The same issue appears to have been experienced, at least to some extent, throughout the province. Nevertheless, then Minister of Seniors and Community Supports, Greg Melchin, replied to Dr. Urness that institutional care for people with developmental difficulties, " … reduces an individual's quality of life and many not be an effective approach in addressing a person's needs." He noted that the population of the Michener Centre was aging and placing young people with aggressive behaviors in that environment would put that population at risk.

Briefing materials also document other issues relating to the transition from an institutional model to a community-based model. "Staffing issues" within PDD itself were noted. More importantly (and consistently), however, a lack of resources in the community was seen as a significant impediment to placement of persons with complex needs into community facilities. In one Briefing Note the Minister was advised that:

> Most Persons with Developmental Disabilities (PDD) service providers are facing significant staffing shortages and report that they cannot provide the type of intensive and extensive supports that individuals at Centennial Centre [CCMHIB] or other mental health facilities require, due to lack of staff. This restricts the PDD regions' ability to accept the individuals that mental health services are ready to discharge.
>
> In some cases, the PDD placements and supports provided by a service provider for an individual with complex needs may be terminated with little or no notice due to challenging behaviors, staffing issues or other reasons.
>
> There can be difficulties arranging supports for an individual deemed ready for discharge from Mental Health Services, as the person would require new housing as well as new services. Transition to new arrangements, especially for some individuals with complex needs, is often difficult for the individual and requires increased time to achieve successfully.

Professionals working at CCMHBI (including Dr. Urness and Dr. Campbell) objected to 'housing' individuals such as Saddleback at their facility for extended periods of time. The CCMHBI was, first and foremost, a hospital. It was designed to treat or stabilize those suffering from mental disorders and then release them to other caregivers in the community. Once CCMHBI reached the limits of its ability to treat an individual and (s)he was ready for discharge, its role was largely complete. It was never intended (at least in the view of professional staff at CCMHBI) that CCMHBI would act as a long-term residential facility for those who were no longer being 'treated' for health or mental health concerns.

This friction led to repeated and some acrimonious interaction between staff at CCMHBI and PDD during the relevant time frame. Dr. Campbell, in particular, was a vocal critic of what he considered to be the misuse of CCMHBI resources to provide a secure residence for Saddleback. He considered it PDD's responsibility to address that concern by placing Saddleback in another institution such as the Michener Centre. That criticism escalated to the point of threatening to engage the media.

Despite their best efforts, staff at PDD experienced significant difficulty finding a community

placement for Saddleback. Attempts were made to convince WDACS to reverse its decision not to continue caring for him. The Executive Director of WDACS testified at this fatality inquiry that PDD even offered to fund bodyguards for WDACS when they were attending to Saddleback. She declined to accept that offer and, out of concern for the safety of her staff, would not even agree to complete the term of her present agreement with PDD (which extended to March 31st, 2011).

Risk Assessment

Following the violent episode in July of 2009, WDACS staff participated with one of PDD's Psychology Assistants in the preparation of a risk assessment relating to Saddleback. Risk Assessment Notes had been prepared by that Psychology Assistant in June of 2008. Nevertheless, he prepared an Update Report on August 25th, 2009. The Update Report is clear and emphatic. Risk is 'rated' in that report both with respect to the nature of potential consequences and the likelihood of them occurring. The report states:

> The Consequence Scale is rated from 1 to 5 with 1 being insignificant and 5 being catastrophic. The consequences for Terrence's (Saddleback's) aggressive outbursts were rated from Major, Level 4 to Catastrophic, Level 5.
>
> The Likelihood Scale is rated from 1 to 5 with 1 meaning rare and 5 meaning almost certain. The likelihood that he will continue this behavior is rated as Level 5, and is almost certain and expected to occur again. Terrence's guardian and past records indicate that incidents have occurred regularly every six months to a year in the past, and he has been admitted to Centennial Centre, Ponoka four times in five years.

The Report addresses potential consequences of Saddleback's outbursts according to a Risk Analysis Guide published by PDD Alberta in March of 2008. It states:

> The consequences could be extensive and irreversible – including death or permanent disability to the staff or support workers involved. During the last incident RCMP officers queried the legitimacy of assault charges against him, even given his level of disability. For the Service Provider this equates to a lawsuit that threatens the organization's viability both financially and politically.
>
> For Terrence [Saddleback], the consequences could include serious but not permanent injury/disability; loss of his home; arrest or conflict with the law; and loss of other valued activities. He indicated later that he had a sore shoulder, there was bruising visible on his body, and he displayed both physical and emotional effects from the incident. Because he is so unpredictable, access to community activities is severely curtailed and he is seldom taken out in public.
>
> For support staff, there could be extended lost-time injuries and/or wholesale staff resignations. There were three WCB claims filed by injured staff from the last incident. His aggression toward staff leads them to suspicion and limitations on their willingness to interact closely with him.
>
> The impact of his outbursts on his peers is harder to assess, but staff have reported a number of observances – behaviours or comments by those individuals that they considered to be notable.

The Report states that Saddleback would continue to be a **High Risk** [emphasis in report] for repetition of this behavior, " … even with adequate supports in place." It then concludes with the following passage:

> He [Saddleback] should not return to a proprietorship. The most pressing concern is to maintain safety. Staff and other clients have to be able to recognize the warning signs and evade Terrence prior to an attack. Currently, the only option is to call for RCMP assistance. Staff who know Terrence and have witnessed his outbursts are firm in their conviction that, "It will happen again."

The author of this report testified that he made a handwritten endorsement to the last paragraph of this report adding that Saddleback ought not to be returned either to the group home under the staffing model (such as WDACS) or a proprietorship (placement with a family). The report was placed on Saddleback's PDD file in Red Deer. There was conflicting evidence about the distribution of this report prior to Saddleback's discharge from CCMHBI in December of 2010. It was certainly available to all PDD staff. It was not shared with CMHA.

Immediately prior to his placement with CMHA, PDD staff knew was aware of the following facts about Saddleback:

(1) he had a lengthy, documented and serious history of aggression
(2) his aggression appeared to be escalating in frequency and severity
(3) acts of physical aggression were unpredictable
(4) physical intervention and, in the last case, the use of pepper spray and physical restraints (handcuffs) were required; and
(5) women were a frequent target of his aggression.

Saddleback's Discharge to CMHA

The evidence I have heard at this fatality inquiry satisfies me that staff at PDD were under significant pressure to find a proprietorship for Saddleback in the community. Saddleback's primary treating physician at CCMHBI, Dr. Campbell, was insistent that PDD immediately facilitate the discharge of Saddleback from the hospital to another location. Pressure was exerted upon Government of Alberta staff from the Minister on down as well. I am also satisfied that PDD went to great lengths to locate a suitable location but was unable to do so. They went so far as to suggest that Michener Centre be renovated to accommodate individuals such as Saddleback. It was also suggested that an 'RFP' ('Request for Proposals') process be engaged to have someone in the community agree to create a facility which could accommodate him. In hindsight, it would appear that an institution, facility, group home or residence capable of supporting Saddleback simply did not exist at that time.

In May of 2010 PDD contacted CMHA staff to consider entering into a Service Agreement to provide community services for Saddleback, including supervised housing on a 24/7 and 1:1 staffing basis. Saddleback's behavior prompted PDD staff to offer enhanced funding for his care. The precise information supplied by PDD and/or CCMHBI staff to CMHA is unclear. In its submission at this fatality inquiry, the Ministry of Human Services has summarized what it considered to be the information provided by PDD to CMHA as follows:

- TS [Saddleback] was a large (approximately 6'5", 250 – 300 lb.) man
- Five RCMP officers were needed to subdue him in an incident in July 2009, which resulted in his admission to Centennial Centre [CCMHBI]
- TS's previous service provider was no longer willing to provide services
- Centennial Centre was intending to discharge TS and had been intent on doing so for a year or more
- TS had a history of aggression to others and intimidated others either through verbal threats or by utilizing his considerable size
- Aggression was a behavior of concern, with a high risk, as TS was big and strong and did not understand the impact of his size and strength on others

- TS had displayed behavior suggesting an underlying psychotic condition but "that was unknown"
- TS's behavior placed him AND OTHERS at direct risk of hurt or harm [emphasis in submission]
- TS was motivated to seek status and would work to ensure he was in control of those around him. When that control was threatened or challenged, an aggressive response was likely.
- Inability to cope with stress coupled with poor insight, limited proactive stress management skills and the presence of triggers was a combination of factors likely to produce frequent aggressive outbursts
- When agitated upset, anxious, frustrated, over stimulated or challenged, TS would easily become aggressive and violent, causing property damage and attacking others (**staff** and roommates). Several incidents had led to police involvement and TS being admitted into hospital [emphasis in submission]
- TS required **extensive support** in prevention of assaulting and injuring others [emphasis in submission]

This information is said to have been provided to CMHA by PDD both verbally and by way of written materials. It has been acknowledged at this fatality inquiry that the information provided was inadequate. First, the written materials provided were few. There were 4 documents in total with the most comprehensive being a 'Behaviour Management Program' dated March 27th, 2008 (well before several acts of aggression, including the July 2009 incident – see *supra*). Second, one of the documents provided, entitled a 'Supports Intensity Scales Report' (or 'SIS' Report) and dated April 30th, 2010, omitted 9 pages of detailed reporting. In those pages was a reference to the need for constant availability of staff capable of applying physical restraint to Saddleback. Third, and most significantly, they did not include either the Risk Assessment notes prepared in June of 2008 or the Risk Assessment Update Report prepared in August of 2009.

Witnesses were questioned about the paucity of materials provided to CMHA, given the wealth of information held by or available to PDD relating to Saddleback's past. No adequate explanation has been forthcoming. A PDD staff member who assembled those materials testified that she did not have the Risk Assessment notes or Update Report to provide. It apparently resided on a file in Red Deer that was either not checked or not known by other PDD staff. While the substance of WDACS' election not to continue providing care to Saddleback may have been made known to CMHA, neither the Executive Director's letter nor any of WDACS' documents (including the many Incident Reports) were disclosed.

In addition to materials supplied directly by PDD, CMHA was provided with CCMHBI's 'Discharge Summary' relating to Saddleback. Curiously, the copy initially provided omitted significant information in the area entitled "Summary of History / Significant Interventions / Significant Investigations / Discharge Recommendations". A number of days after providing the incomplete copy, a completed version was faxed to CMHA. It contained more information about Saddleback's aggressive acts. CCMHBI's Multidisciplinary Notes were not provided to CMHA, likely due to their voluminous nature, scattered relevance and the absence of any request to do so.

Finally, and in addition to the 4 documents provided to CMHA, PDD facilitated a meeting for the purpose of putting CMHA in touch with those involved in Saddleback's care. On October 21st, 2010, 5 members of CMHA's staff met with a representative of PDD and CCMHBI staff (a nurse and a social worker). None of the principal attending physician, Dr. Campbell, a CCMHBI nurse who was familiar with Saddleback, a representative of WDACS or Saddleback's guardian were present.

Discussion at this meeting centered around Saddleback's behavior and behavior management while a patient at CCMHBI. CMHA staff were told of an incident where Saddleback had pulled the ponytail of a female nurse. They were told of Saddleback's sexual proclivities, including a preoccupation, with pregnant women and/or young children. They were also told of the ease with which Saddleback could be managed or 'redirected' and that there were no problems with having him take medication (or PRN's). No reference was made to PDD's Risk Assessment or Update Report of August 2009. Several CMHA attendees at this meeting recalled reference being made by CCMHBI staff to Saddleback as a "teddy bear" or "gentle giant".

Although Saddleback's guardian was not in attendance at the October 21st, 2010 meeting, he gave evidence that he had been in touch with CMHA staff (as required by CMHA's operating procedures). He gave evidence that he emphatically warned staff about the hazard presented by Saddleback. The staff member who he spoke to emphatically denied that she had been warned in any manner. I am unable to draw any conclusion on this point based upon this contradictory (and equally believable) evidence.

Whatever information was received by CMHA as an organization, I am satisfied that only parts of that information were conveyed to staff directly involved in caring for Saddleback. I emphasize that there has been no suggestion that CMHA withheld or consciously avoided disseminating this information amongst its staff. Given assurances provided to CMHA at the October 21st, 2010 meeting, it seems probable that information relating to Saddleback's aggressive tendencies was not emphasized or perhaps even relayed to all CMHA staff. It may have been assumed that those aggressive tendencies had been 'handled' by his prolonged stay at CCMHBI and the non-restrictive procedures available to CMHA staff could effectively manage Saddleback's behaviour.

Considerable evidence was heard with respect to CMHA's accreditation and the level of care it was capable of providing. I will not summarize that evidence in this Report other than to say that it is curious that organizations are permitted to provide services beyond their stated level of accreditation simply because they are working toward attaining that other form or higher level of accreditation. In this case, PDD provided extra funding in order that CMHA staff could receive the training they needed in order to deal with Saddleback. It was in progress at the time of Wolski's death.

Based upon the evidence heard at this fatality inquiry, I am satisfied that both PDD and CCMHBI were aware that CMHA had a 'no restraint' policy in effect at the time they took charge of Saddleback; CMHA staff could not engage in 'restrictive procedures'. A Behavioural Consultant with PDD testified that CMHA was very limited in the tools available to it to control an individual such as Saddleback. They could not use any form of physical force, for instance. They could not even enforce a 'time out' procedure. CMHA staff were largely limited to providing (but not 'administering') medication (such as PRNs). They could 're-direct' Saddleback but, in the face of physical aggression, their remedy beyond redirection and/or PRNs was simply to retreat and, if necessary, call for assistance. PDD was also aware that CMHA, like other community service providers, employed primarily female staff.

All of the organizations whose representatives testified at this fatality inquiry were subject to various policies and protocols when acting as caregivers. Their respective levels of awareness and application of those policies and protocols varied considerably. One example is the policy binding CMHA staff <u>not to administer</u> PRNs (a form of medication used to control a client's behavior). I have nonetheless heard evidence that procedures adopted by some CMHA staff often amounted to administration of those PRNs. One staff member testified that she had brought this to the attention of the Executive Director. A request was then made by CMHA to have an agency qualified to administer medication to Saddleback attend and do so.

CMHA ensured that each of Saddleback's caregivers had a cellular telephone for use in case of

an emergency. One staff member testified that, apart from the cell phone, she was instructed by CMHA to do whatever was necessary to protect herself in the event of aggression by Saddleback. This meant to first call 911 and then "run like hell". The same staff member actually removed a door lock from the bathroom of the premises housing Saddleback and reinstalled it on the staff room door so that staff could lock Saddleback out until help arrived.

Valerie Wolski

Wolski was an experienced Individual Supports Worker. She possessed a Bachelor of Arts degree in psychology and took considerable training while working with CMHA's crisis team. She took on leadership of that team from 2005 to 2010. Wolski was also a woman of small stature; she stood less than 5 feet tall.

The Executive Director of CMHA had discussed with Wolski the prospect of her working with Saddleback and Wolski agreed to do so. Saddleback had actually stayed overnight from time to time at a CMHA facility during the transition period (from CCMHBI to CMHA) and Wolski participated in caring for him in that context. When asked by the Executive Director how things were proceeding with Saddleback, Wolski replied that they were going very well.

There was evidence at this fatality inquiry that a relative of Wolski's had previously worked with Saddleback. That relative had apparently alluded to Saddleback's aggressive tendencies in conversation with Wolski and recommended that she not take any role in his care. Wolski likely discussed this with her superiors at CMHA but, having regard to the foregoing, was provided with less than the full picture of Saddleback's aggressive tendencies. She elected to continue with his care. When asked why Wolski would do so, a co-worker testified that, "She was the type of person who would do anything to make somebody happy."

Wolski attended CMHA's residence housing Saddleback on the afternoon of February 12th, 2011. The two remained alone in the premises thereafter. Wolski's husband, Eugene Wolski, texted her that evening but received no reply. This understandably caused him no concern as it had happened more than once in the past.

The following morning, Wolski's co-worker showed up at the premises. When she entered, she saw Wolski prone on the floor of the living room area. It was apparent that she had been dead for some time. Saddleback was asleep on a nearby couch. Wolski's hair was "all over" the kitchen counter. The co-worker screamed out Wolski's name and Saddleback awoke. He greeted her and moved toward her. She saw that his shirt was covered in Wolski's hair. The co-worker grabbed Wolski's cell phone (which had been charging on the counter) and fled the premises. She entered her car, locked the doors and called 911. Police ultimately arrived, took Saddleback into custody and began their investigation.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

Before making my recommendations, some preliminary comments are in order. The provisions of the *Fatality Inquiries Act,* R.S.A. 2000, c.F-9, s.35(3) (the '*Act*') direct that, "(3) The findings of the judge shall not contain any findings of legal responsibility or any conclusion of law." I have been invited in submissions to make findings which at least approach these prohibited actions. For example, I have been asked to determine whether CMHA was required to be certified by the Alberta Council of Disability Services before they performed services for Saddleback.

Apart from any restrictions imposed by the *Act,* s.35(3), I am not satisfied that inquiries into or conclusions relating to issues of that nature will assist me in exercising my statutory authority to make, " … recommendations as to the prevention of similar deaths," (*Act*, s.35(2)). The

Government of Alberta is responsible for ensuring proper care for developmentally disabled persons presenting complex needs. The qualification, selection, monitoring and accountability of those providing services in that regard are all parts of that responsibility. There were direct and immediate failings in this case which contributed to the death of Wolski. Many, if not most of those failings have been acknowledged in evidence before me. I choose to make recommendations directly addressing those failings rather than areas which approach findings of legal responsibility or what may amount to conclusions of law.

Wolski's death took place in 2011. This fatality inquiry, including my Report, will be concluded in 2016. Intervening between the fatality and this inquiry were a series of events. Most notably, the Ministry of Human Services, Occupational Health & Safety ('OHS') undertook a thorough investigation of Wolski's death and issued a variety of compliance orders. An appeal was taken from findings made during the course of that investigation. Those proceedings no doubt contributed to delay. The delay is unfortunate as my recommendations are based largely upon events that occurred many years ago.

Witnesses testifying at this fatality inquiry have felt the effects of Wolski's tragic death in both their personal and professional lives. Indeed, at least one witness left his employment as a result of this fatality and continues to have nightmares relating to it. I am satisfied that these individuals and the organizations to which they belong have already taken some positive steps to change their practices in order to prevent a similar occurrence. PDD, to its credit, complied with all orders made by OHS during and after its investigation. As a result, some of the recommendations made by me in this report already may have been implemented.

Witnesses at this fatality inquiry were invited to comment on what they felt ought to be done in order to avert similar deaths in the future. I have benefitted from their input and, in particular, the input of Eugene Wolski. While I have not individually referenced any of those comments in my recommendations, they certainly have been taken into account.

A consistent comment made by those testifying at this fatality inquiry was that the Michener Centre or a similar institution should remain or be made available for developmentally disabled persons presenting complex needs; someone like Saddleback. While I have some sympathy for those comments, it must be recognized that it is for the government of the day to make policy elections about the assessment, treatment and continuing care of developmentally disabled adults presenting complex needs. The efficacy of any particular policy election is beyond the ambit of this fatality inquiry. Moreover, the evidence heard during the course of this fatality inquiry would be insufficient for me to make an appropriate recommendation in any event.

Regardless of the policy option selected, however, all those participating in this fatality inquiry recognized the overarching need to keep caregivers safe when caring for developmentally disabled persons presenting complex needs. I am satisfied that during the time frame relevant to Saddleback's final placement, there was no community resource available to PDD that was capable of providing the level of safety required. CMHA was not capable of providing the level of safety required by its caregivers when caring for Saddleback.

Recommendation #1: I recommend that PDD engage an outside agency to review and assist with any changes necessary to improve the manner in which that organization generates, secures and disseminates information to caregivers relating to developmentally disabled clients.

The evidence heard at this fatality inquiry satisfies me that the manner in which PDD generated, secured and disseminated information relating to Saddleback as a developmentally disabled client was deficient. The full SIS Report of April 30th, 2010 and Risk Assessment Update Report prepared in August of 2009 are but two examples of documents or information which would be critically important to a community based caregiver such as CMHA. Indeed, CMHA staff testified that Saddleback would not have been taken on as a

client had that information been made available to them. It is simply no answer to this deficiency to point out that a report or assessment was in Saddleback's file in Red Deer and not available for enclosure with the scant materials provided to CMHA before it agreed to provide services for him.

Those with expertise in business management and information management need to be engaged to ensure that there is, at the very least, a cumulative inventory of all documentation held by PDD (wherever its staff may operate) in relation to a developmentally delayed adult whose care it is funding. This inventory (preferably in electronic format) should be appropriately indexed by subject-matter, dated and make reference to the author of the document. Anyone responsible for transferring information from PDD to an organization such as CMHA should be required to provide an up-to-date copy of that inventory to that organization.

In addition to the inventory of documentation held by PDD or its staff, PDD should ensure that there is an inventory of all documentation held by any organization that has previously been engaged to provide care to a developmentally disabled person funded via PDD. This inventory should contain, at the very least, the information noted above. When transferring a client from one organization engaged to provide care to a developmentally disabled person funded via PDD to another, PDD should ensure that the inventory from that earlier organization (or organizations) be up-to-date.

These inventories should be the subject of review by PDD with any organization engaged to provide care to a developmentally disabled person funded via PDD. With the exception of safety concerns (which will be addressed later in these recommendations), PDD should exercise its judgment to ensure appropriate privacy interests are protected but otherwise facilitate access to any documentation contained in these inventories to the organization it agrees to fund. Where privacy concerns arise, redacting, waivers or other methods of securing privacy should be engaged. PDD should engage an internal review procedure whenever any document listed on the inventory is requested by an organization but withheld by PDD.

Both PDD and any organization engaged to provide care to a developmentally disabled person funded via PDD should be required to 'sign off' on both the inventories and inspection of documents before the client is placed in the care of that organization. Any information withheld should be noted, together with explanations for that withholding and confirmation of a review. The obligation upon PDD to bring to the attention of an organization engaged to provide care to a developmentally disabled person funded via PDD must be a continuing obligation. That is to say that if information relating to a developmentally disabled person funded via PDD comes to the attention of PDD once the client is placed in an organization's care, it must ensure that the applicable inventory is updated and provided to that organization together with an invitation to review any documentation contained in it.

Recommendation #2: I recommend that CCMHBI engage an outside agency to review and assist with any changes necessary to improve the manner in which that organization generates, secures and disseminates information relating to developmentally disabled clients to PDD or others meeting the needs of those clients.

I am satisfied from the evidence heard at this fatality inquiry that, following the meeting of October 21st, 2010 at CCMHBI, CMHA staff was left with the erroneous impression that Saddleback's aggression and sexual proclivities were such that they could be managed by an organization (such as CMHA) which had a 'no restraint' or 'no restrictive practices' policy. I pause to emphasize that this should not be construed as a finding that CCMHBI staff intentionally misled those from CMHA. Rather, the information provided, supplemented by oral commentary was reasonably, but mistakenly construed in this fashion.

I will not repeat the list of practices or procedures I have outlined in Recommendation #1 in

relation to PDD. Providing an inventory of this nature and engaging a review of that inventory and/or any information contained therein for an organization engaged to provide care to a developmentally disabled person funded via PDD and kept in CCMHBI would help prevent the obviously inadequate flow of information from CCMHBI to CMHA that occurred in this case. Privacy interests peculiar to CCMHBI can be addressed in a fashion analogous to that noted for PDD.

Recommendation #3: I recommend that PDD, CCMHBI and any organization engaged to provide care to a developmentally disabled person funded via PDD be required to keep a separate inventory, file or record of all information relevant to the issue of safety when dealing with that developmentally disabled person. This would apply both to information generated by those bodies or provided to them.

I have had the opportunity to review a wide range of documents in the form of notes, certificates, forms, records, reports, summaries and assessments used by various organizations involved in arranging for or providing care to developmentally disabled persons funded via PDD. Each serves its own purpose and is likely helpful to the department, organization or individuals using it. In this case, information relating to Saddleback's safety, the safety of his caregivers and the safety of members of the public is scattered in bits and pieces throughout various documents. It is recorded, processed, reviewed, disseminated and filed in a variety of ways. And some of the documents containing that information, such as the Multidisciplinary Notes, are voluminous.

Information relating to safety is special. This fatality inquiry has made that clear. And in order for information relating to the safety of his caregivers to produce the desired effect, it must be segregated from the morass of documents relating to the developmentally disabled person's care, financial circumstances, etc. In short, there must be a discrete and informative '**Safety Record**'.

PDD, CCMHBI and all those involved in the care of a developmentally disabled person funded via PDD should be required to keep all documents relevant to the safety of those providing care to that person (or copies of those documents) in their own Safety Record held by the organization and made available to all staff. It would contain documents such as the 'Incident Reports' generated by WDACS, the Risk Assessments and Updates prepared by PDD, and any entries in CCMHBI's Multidisciplinary Notes relating to assaults, hair-pulling, threats, etc.

PDD must ensure that, whenever care of a developmentally disabled person funded via PDD is transferred from one entity to another, the Safety Record or a copy thereof is first provided to an intended caregiver, together with an opportunity to review its contents or any documentation pertaining to those contents. Caregivers cannot be expected to have knowledge of all documentation held by other organizations that may be relevant to safety. Potential caregivers may be unaware of the fact that Multidisciplinary Notes held by CCMHBI may contain scattered references to information relating to caregiver safety. And, even if they did, it is resource-inefficient to expect them to spend the time necessary to review such voluminous records.

Privacy concerns can likely be attended to in the manner described in earlier recommendations. Having regard to the focus on safety and prevention of significant harm to the health and safety of those involved, the provisions of the *Freedom of Information and Protection of Privacy Act,* R.S.A. 2000, c.F-25, s.32(1)(a) would likely apply.

In addition to the Safety Record, PDD, CCMHBI and all those involved in the care of a developmentally disabled person funded via PDD should be required to prepare a succinct document styled a '**Safety Report**' and provide that report to any organization or individual about to take over caregiving responsibilities for a developmentally disabled person. The Safety Report should signal to caregivers the risk to safety posed by the person whose care they are about to take over. The Report could be as short as 1 page in length but should in

any event be no more than 3 pages in length.

The content of the Report will need to be the subject-matter of discussion amongst PDD, CCMHBI and those organizations or individuals assuming responsibility for the care of a developmentally disabled person. Where the person poses no potential risk to safety, the Safety Report might simply display a checkbox next to an entry entitled: "No risk to safety." Where the potential risk to safety is, as it was in the case of Saddleback, "major" or "catastrophic" these or analogous entries can be created. Designations may need to be expanded upon although emphasis should be placed upon keeping the Safety Report brief.

The efficacy of a succinct Safety Report in impactive language is that it could be quickly read and easily understood not only by doctors, psychologists or management staff involved in the care of developmentally disabled adults but also by all other staff whose interest and involvement with that person may be more modest. Review of the Safety Report should be mandatory for all those involved in the care of the developmentally disabled person.

Recommendation #4: I recommend that PDD refrain from permitting organizations from providing services for which they are not properly accredited until the appropriate body has actually provided that accreditation.

I have previously expressed some curiosity about the practice of permitting an organization to provide a level of care to a developmentally disabled person when its formal accreditation does not extend to that level of care. I am aware that a developmental period for those organizations may be required. However, when this is to occur, both PDD and the organization engaged should clearly acknowledge that dynamic in their service agreement. In addition, PDD should ensure that some form of review or monitoring take place during the course of development and until the appropriate body has provided the necessary accreditation.

Recommendation #5: I 're-recommend' that, at no time should a careworker be assigned to the care of a resident that the careworker cannot physically manage at that time.

In his *Report to the Minister of Justice and Attorney General: Public Fatality Inquiry into the Death of Sharla Marie Collier* ('*Collier Report'*), Malin P.C.J. recommended that: "At any time, a careworker should only be assigned to the care of a resident that the careworker can physically manage at that time." More will be said of the *Collier Report* in a recommendation to follow. Nevertheless, it would appear obvious that a diminutive Individual Supports Worker such as Wolski ought not to have been assigned responsibility for the care of a young and very large man such as Saddleback. This, despite the worker's willingness to do so. The only exception to such an arrangement would be circumstances where the client presents no risk to safety.

Recommendation #6: I recommend that, at no time should a female careworker be assigned exclusive care of a client who has previously expressed or demonstrated aggression toward females.

While, at times, Saddleback demonstrated aggression toward males, he had a proclivity to attack females. In particular, he would grab them by the hair. It is not without significance that he had pulled out significant quantities of Wolski's hair at some time before or after her death. I appreciate that the majority of careworkers at organizations such as CMHA are female. It is for that reason that I have qualified this recommendation by referencing "exclusive care". It may be that the presence of more than one female caregiver would provide a sufficient safeguard.

Recommendation #7: I recommend that the Government of Alberta prepare an implementation report on the status of implementation of recommendations from all

fatality inquiries.

Prior to convening the fatality inquiry into this matter, I directed Inquiry Counsel to review past fatality inquiry reports in order to determine if any fatalities similar to this had occurred in the past. If so, those reports may be of assistance to me in considering what recommendations should be made for the prevention of similar deaths. Acting in accordance with those directions, Inquiry Counsel located and provided me with the *Collier Report*. While not identical to the instant case, the *Collier Report* involved a situation where a careworker was killed by the resident of a group home in Lethbridge, Alberta.

The female careworker in that case was 20 years old, 5 feet 1 inch tall and weighed approximately 165 pounds. The male resident who killed her was 14 years old, 5 feet 4 inches tall and weighed 90 pounds. The resident suffered from fetal alcohol spectrum disorder (FASD) and attention deficit hyperactivity disorder (ADHD). He had no criminal record and, " … did not have a notable record of violence towards others." In a section of the *Collier Report* entitled "Risk Assessment of the Offender" Malin P.C.J. noted that group home staff and managers, " … did not assess the offender as a risk to the personal safety of the careworkers."

The careworker was killed by the resident on the afternoon of November 16th, 2002 when the two were walking on a pathway near the Oldman River. The resident struck his careworker on the head with a fallen tree branch, likely when her back was turned. The initial blow and those following led to her death. The resident then proceeded to sexually assault her.

On December 3, 2008 Malin P.C.J. released the *Collier Report*. I will not review that report or the recommendations contained in it in this report. Nevertheless, Malin P.C.J. made at least one recommendation for the prevention of similar deaths which is of relevance to this fatality inquiry. That recommendation was:

> At any time, a careworker should only be assigned to the care of a resident that the careworker can physically manage at that time.

Despite the best efforts of Inquiry Counsel, the Government of Alberta's response to these recommendations could not be ascertained. And, if experienced counsel, acting at the direction of a Judge appointed in accordance with the *Fatality Inquiries Act,* R.S.A. 2000, c.F-9, s.35 has been unable to determine whether those recommendations were acted upon, it is unlikely that a member of the public, community groups or the media could do so. My earlier recommendation in this regard may be unnecessary (or more nuanced) depending upon what action the Government of Alberta has taken in relation to Malin P.C.J.'s earlier recommendation.

In its submission at this fatality inquiry, the Ministry of Human Services has advised that it, " … carried out the seven specific measures set out in the OHS Order notwithstanding the appeal." This included a measure designed to, "[e]nsure all contracts for placement of high-risk individuals provide for proper staffing levels to mitigate the hazard of working alone." This would suggest that such a requirement may not have been in place at the time PDD entered into its service agreement with CMHA. If that is the case, one is left to wonder whether Wolski would be alive today if the recommendations made by Malin P.C.J. back in 2008 had been followed.

The Government of Ontario investigates deaths by a system known as a 'Coroner's Inquest'. A 'Coroner' (physician) presides over a 'jury' of five (members of the community) who are charged with the responsibility of answering the following questions:

1. Who was the deceased?
2. Where did the death occur?
3. When did the death occur?
4. How did the death occur (i.e. the medical cause)?
5. By what means did the death occur?

The jury's responses to these questions are collectively referred to as its 'verdict'. The jury is also entitled to make recommendations for the prevention of similar deaths.

Unlike Alberta, however, Ontario mandates a report on which, if any recommendations made at an inquest have been implemented. The Ontario Ministry of Community Safety & Correctional Services reports that:

> The [jury's] verdict and recommendations, along with a brief explanation written by the presiding coroner, are sent to the Chief Coroner for distribution to agencies, associations, government ministries, or other identified organizations that may be in a position to implement the recommendations. Recipients are asked to evaluate their response to the recommendations and are requested to submit their response to the Office of the Chief Coroner within a year of the inquest. Members of the public, including the media, may request a copy of responses to inquest recommendations by submitting a written request to the Office of the Chief Coroner.
>
> The Office of the Chief Coroner prepares an implementation report on the status of implementation of recommendations from all inquests. Implementation reports are published in an annual report on inquests that is available to the public. (emphasis added)
>
> See: http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Inquests/AidtoInquests/AidToInquests.html

Fatality Inquiries are costly endeavors. In this case, Inquiry Counsel was charged with the responsibility of seeking out and reviewing approximately 25,000 pp. of materials. Culled from those were approximately 2500 pp. of material which had to be copied for, distributed to and reviewed by interested parties and the court. The inquiry engaged three lawyers in addition to Inquiry Counsel and occupied a full two weeks of court time. Numerous witnesses were heard and exhibits filed.

This Report, like that of the Malin P.C.J. will make recommendations intended to prevent similar deaths. And, while it is for the Government of Alberta to determine whether any or all of these recommendations should be implemented, it is important for community agencies, the media and members of the public to know what action (if any) has been taken pursuant to those recommendations. It would have been useful for me to know whether the recommendations made by the Malin P.C.J. in the *Collier Report* were acted upon or rejected.

DATED November 10, 2016,

at Edmonton, Alberta.

Original signed by

B.D. Rosborough
A Judge of the Provincial Court of Alberta