

**REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT**

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at the Court House
in the Hamlet of Sherwood Park, Alberta
(City, Town, etc.) (Name of City, Town, etc.)
on the 14th day of January, 1999 (and by adjournment
on the 15th day of January, 1999), before
Raymond Wilson Bradley, a Provincial Court Judge.

A jury was was not summoned and an Inquiry was held into the death of
Mary Ann KORCHINSKI 43 Years Old
(Name in Full) (Age)

of 7-23 Woodbine Court (Robin Hood Association) and the following findings were made:
Sherwood Park, Alberta (Residence)
Date and Time of Death on or about the early morning of February 22, 1998
Place 7-23 Woodbine Court (Robin Hood Association), Sherwood Park, 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))

Medical asphyxia (wedging)

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))

Accidental

REPORT TO AG 338 - PAGE 2

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

The decedent, Mary Ann Korchinski, was in a long-term care facility for mentally handicapped persons. She died as a result of mechanical asphyxia (wedging) as a result of being trapped in the side rails of her bed.

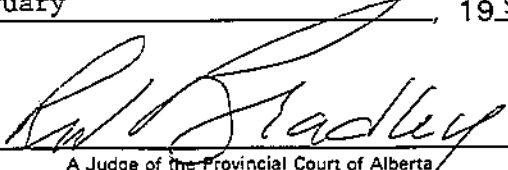
No. of additional pages attached 0

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

See Attached

No. of additional pages attached 1

DATED this 26th day of February, 1999.


A Judge of the Provincial Court of Alberta
(Raymond W. Bradley)

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

The love and care extended to Mary Ann Korchinski by her family prior to and during her care with the Robin Hood Association was clearly illustrated in the evidence before this Inquiry. Further, the presence and participation in the Inquiry by the family confirmed their desire to insure the prevention of similar accidents.

The Inquiry acknowledges the assessments and steps taken by the Robin Hood Association relative to prevention and in particular the placement of bed rail coverings.

This Inquiry makes the following recommendations for the prevention of similar deaths:

- (1) While the Inquiry takes notice that providers in the Health Care industry are under financial pressure **this Inquiry recommends that funded 24-hour awake staffing be provided in care facilities for mentally and physically challenged persons.**
- (2) Evidence presented to this Inquiry established that medical devices and equipment, such as the bed rail being considered by this Inquiry, are often purchased through Alberta Aids to Daily Living (referred to as A.D.L.) funded in whole or in part by the Province of Alberta. To obtain funding the device or equipment has to be approved by A.D.L. and the railing in question was so approved.

During the Inquiry counsel for the Robin Hood Association ascertained and placed before the Inquiry a Medical Devices Alert on the subject of: Hazard with Hospital Bed Split Side Rails, published by the Health Protection Branch, Health Canada, #107 dated August 10, 1995. From the evidence it would appear that Alerts from Health Canada or their United States counterparts were not known to A.D.L.. **This Inquiry recommends that the Government of Alberta, through an appropriate department such as Alberta Health or Alberta Family & Social Services, require that Alerts from the Health Protection Branch, Health Canada be circulated to health care suppliers such as A.D.L. and Health Care facilities. If such a system is already in place there should be an assessment to insure the system is working. Further, there should be periodic checks to insure continued timely dissemination of this information to relevant health care suppliers and providers.**

- (3) Evidence at the Inquiry indicates that in the United States there is legislation requiring hospitals and other user facilities to report deaths, illnesses and injuries associated with the use of medical devices. The Health Canada Alert in evidence invites inquiries and reports of problems and accidents. **It is recommended that the Alberta Government, in conjunction with recommendation #2, consider a requirement that health care suppliers and providers report deaths, injuries or illnesses associated with the use of medical devices to the Health Protection Branch, Health Canada. If such reporting is already required it is recommended that a reminder be circulated to health care suppliers and providers.**