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 Grande Prairie Court House

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

on the 14th day of July, 2010 (year), (and by adjournment

on the 15th day of July, 2010 (year)),

before The Honourable Judge G. William Paul, a Provincial Court Judge,

into the death of Charles Robert Ramsey (Name in Full) 50 (Age)

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

Date and Time of Death: April 9, 2007 at 1620 hours

Place: QE II Hospital, Grande Prairie, 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)).

a) Presumed Ethanol and/or drug withdrawal
b) Chronic Ethanol and Drug Abuse

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)).

Natural

Circumstances under which Death occurred:

CHRONOLOGY OF EVENTS

Charles Robert Ramsey, born November 25th, 1956 was a resident of a hotel room in Fairview, Alberta on March 31, 2007 when he called to have an ambulance attend to transport him to the Fairview Health Complex. He was admitted to the Fairview Health Complex at approximately 5:40 o'clock p.m. on that day. Shortly after 10:00 o'clock p.m. Mr. Ramsey was found to be unresponsive. He was transported shortly thereafter to the QE II Hospital in Grande Prairie, Alberta for conduct of a CT scan out of concern that he may have an undiagnosed head injury.

Mr. Ramsey was admitted to the Intensive Care Unit (ICU) of the hospital to await the CT scan, that being the only available place to accommodate him in the QE II Hospital. By this admission he became the patient of Dr. Anthony (Tony) Best, the attending doctor at that time in the ICU. Dr. Best first saw Mr. Ramsey at approximately 5:30 o'clock a.m. on April 1, 2007. The CT scan was conducted at 11:00 o'clock a.m. that morning and Dr. Best confirmed that it was normal.

Mr. Ramsey remained in the ICU. Dr. Best was called by the nursing staff in the afternoon because of disruptive and aggressive behavior by Mr. Ramsey. Mr. Ramsey was thrashing about and rocking back and forth on his bed and demanding narcotic drugs from Dr. Best. He was cursing and thrashing about and thereby creating danger of physically damaging the bed. He was restrained by those present and restraints were placed on him to control his behaviors.

Dr. Best made inquiries of the Fairview Health Complex and spoke to a charge nurse who told him that Mr. Ramsey had a history of chronic alcoholism and drug abuse and drug seeking behavior. He spoke also to Dr. Cornelius Klassen who confirmed that he had stopped giving Mr. Ramsey narcotic medications about one month before these events and that Mr. Ramsey continued to seek narcotics from the Fairview Health Complex. These conversations left Dr. Best of the opinion that the behaviors displayed by Mr. Ramsey were not unusual when he was attempting to obtain narcotics from health providers. Dr. Best determined that there was no medical reason to have Mr. Ramsey remain in the ICU and in his opinion there was no medical reason that Mr. Ramsey would require the narcotic medications that he was demanding.

Having regard to his behaviors and because Dr. Best was of the view that there was no reason to keep Mr. Ramsey in the ICU he wanted him to be anywhere but in the ICU. Dr. Best had determined from Dr. Klassen that there was no available bed at the Fairview Health Complex and therefore a return of the patient to Fairview was not possible even if for no reason other than to return him to where he was from. Dr. Best suggested that Mr. Ramsey be taken to a "detox centre" in Grande Prairie. Mr. Ramsey declined that offer and involuntary committal to such a centre is not possible.

Dr. Best determined that chemical restraint of the aggressive Mr. Ramsey was not appropriate because that was equivalent to holding the man against his will. Dr. Best testified that the only option was to discharge Mr. Ramsey. He instructed that the RCMP be called because Mr. Ramsey seemed intent on doing damage to the hospital and he did not want to go anywhere and only wanted to obtain narcotic medications. Mr. Ramsey was in Grande Prairie without clothing and for that reason and because of his uncontrollable behavior, Dr. Best was not prepared to discharge him to the streets of Grande Prairie.

Mr. Ramsey was discharged at 2:30 p.m. on April 1, 2007 by Dr. Best as noted on a Physicians Order Sheet which is found at page 27 of Tab 25 of Exhibit #1. The health care providers maintain progress reports regarding patients treated at the hospital. Dr. Best's Progress Notes regarding Mr. Ramsey at page 25 of Tab 25 of Exhibit #1 state:

> *"medically he does not require any intensive care or acute medical therapy; he is obviously at risk for alcohol & opiate withdrawal;"*

A Discharge Summary regarding Mr. Ramsey was prepared and is found at page 5 of Tab 25 of Exhibit #1. Dr. Best included in this summary the following passage:

> *"I do have some concern that he would be susceptible to an alcohol withdrawal seizure."*

Constable Brad White responded to the call from the hospital for RCMP assistance. He was joined at the hospital by Constables Laird and Villeneuve. They found Mr. Ramsey to be restrained on his hospital bed, moaning and thrashing about and making incoherent noises. Cst. White had no success in his efforts to communicate with Mr. Ramsey. Efforts to calm him down were also unsuccessful. Mr. Ramsey remained at all times aggressive, physical and very violent in his behavior.

Cst. White spoke to Dr. Best who advised him to take Mr. Ramsey to Fairview Health Complex or to a detox centre. He was advised by the doctor that Mr. Ramsey was medically discharged, that he was seeking drugs and that they wanted him out of the hospital. Cst. White made the decision to arrest Mr. Ramsey for breaching the peace. He based his decision on the basis of Mr. Ramsey's behaviors, that he was not fit for release into the public, that the AADAC treatment centre would not accept Mr. Ramsey in his state and that it was not the obligation of the RCMP to transport him back to Fairview. Cst. White did not intend ultimately to charge Mr. Ramsey, but rather to place him in cells until he became communicative and calm so that arrangements could be made for his release.

The three officers in attendance removed Mr. Ramsey from the hospital and he was transported by police cruiser to the Grande Prairie RCMP Detachment. His behaviors remained unchanged throughout this time as he continued to moan and groan and make incoherent sounds. When the rear door to the cruiser was opened in the secure bay of the Detachment Mr. Ramsey thrashed his way out of the vehicle and onto the floor where he continued to roll about. It was decided by Cst White, in consultation with other officers present, that for Mr. Ramsey's safety he should be confined in a restraint chair. At no time was there any intention by the officers to use the chair as a form of punishment.

All officers directly involved in matters relating to the use of the restraint chair had received training in use of the device not longer than several weeks previous to this date. Mr. Ramsey was treated with appropriate care in placement in the chair at approximately 3:00 p.m. He was placed alone in a cell where he was monitored by Charlene Klassen, a matron in the cell block of the Grande Prairie RCMP Detachment. Mr. Ramsey was monitored by way of video camera in the cell and by way of regular attendance by the matron at the cell at least every fifteen minutes.

Mr. Ramsey remained in the restraint chair for approximately three hours and fifteen minutes. The manufacturer's instructional manual for use of the Emergency Restraint Chair recommends

that *"Detainees should not be left in the Emergency Restraint Chair for more than two hours. This time limit was established to allow for the detainee to calm down or sober up, and if needed it allows for the correctional office to seek medical or psychological help for the detainee. This two hour time limit may be extended, but only under* ***direct*** *medical supervision (Doctor/Nurse)."* The manual suggests a maximum time in the chair of ten hours.

The RCMP requires as a matter of policy that members read an instructional booklet and view an instructional video regarding use of the Emergency Restraint Chair. The video is provided by the manufacturer and contains the suggestion regarding a two hour time limit for occupation of the chair by a detainee. The video presentation suggests that an individual be removed from the chair for stimulation and placed back in the chair, if required. The booklet contains the recommendations noted above. It is not a matter of official RCMP policy that detainees not occupy a restraint chair beyond the two hour recommendation. Official RCMP policy includes the provisions that *"When the prisoner is composed and responsive, remove the prisoner from the restraint chair. If a prisoner is restrained for more than two hours, document the reason in your notebook and on the file. Ensure that the prisoner is only restrained for as long as it is absolutely necessary."* RCMP policy appears to be that members directly involved with persons in restraint chairs will exercise discretion based upon their own assessment of the individual restrained and that they will make the determination whether restraint beyond two hours should continue and whether medical assistance should be sought.

Mr. Ramsey's behaviors did not change throughout his time in the restraint chair. He was in constant movement and made constant incoherent sounds. When Ms. Klassen spoke to him and called his name he would stop his movement and look in her direction. In short order he would return to his constant agitated and rocking movement and continue making incoherent sounds. At approximately 4:10 p.m. adjustments were made to the restraint chair restraints because Mr. Ramsey's constant movements were causing chafing of his skin. At no time was he removed from the chair. Because of his behaviors, Mr. Ramsey was viewed by Ms. Klassen more often than he would otherwise be. Cst. White viewed Mr. Ramsey through the cell window at approximately 5:45 p.m. and noted his behaviors to be unchanged.

Ms. Klassen became alarmed when Mr. Ramsey stopped making constant incoherent sounds at approximately 6:10 p.m. She checked on him immediately, kicked at the door and screamed his name in an effort to get a response. When Mr. Ramsey did not respond Ms. Klassen immediately notified RCMP members by radio communication of the emergency. Members arrived at the cell in her words "in a heartbeat" and entered the cell at approximately 6:11 p.m. Steps taken included efforts to locate vital signs and the officers believed that Mr. Ramsey was alive but in distress. Mr. Ramsey was removed from the restraint chair to the floor at approximately 6:15 p.m. Efforts were made by the officers in attendance to check for vital signs and administration of a sternum rub to seek a response. Paramedics were summoned and arrived in the cell at approximately 6:18 p.m. They commenced active CPR efforts at 6:21 p.m. They attended to Mr. Ramsey until his removal for transport to the hospital at 6:42 p.m.

Mr. Ramsey remained in the Queen Elizabeth II Hospital in Grande Prairie, Alberta where he was treated until his death on April 9, 2007. He was declared deceased at 4:20 pm April 9, 2007. Subsequent examination by the Medical Examiner resulted in a determination that the immediate cause of his death was "Presumed Ethanol and/or Drug Withdrawal" with antecedent cause being "Chronic Ethanol and Drug Abuse".

ANALYSIS OF EVENTS

Mr. Ramsey was dealt with appropriately by medical providers in Fairview, Alberta when he was sent to the QE II Hospital in Grande Prairie for tests to determine whether medical issues existed that were unknown at the time. He was treated appropriately at the QE II Hospital with respect to provision of the CT scan. No untoward medical issues were found to exist and it was determined that there was no medical reason to have Mr. Ramsey remain in hospital.

Mr. Ramsey's bizarre and uncontrollable behaviors in the QE II Hospital caused the health care providers to seek out information from their counterparts in Fairview, Alberta. The information shared with them was that Mr. Ramsey was a chronic alcohol and drug abuser who often exhibited drug-seeking behaviors. The impression seems to have been left with all health care providers involved that Mr. Ramsey was not acting differently than he might ordinarily act when seeking drugs. The attending physician, Dr. Best, had some concerns regarding a risk to Mr. Ramsey of an alcohol and opiate withdrawal and possible susceptibility to alcohol withdrawal seizure.

When the RCMP members were summoned to remove Mr. Ramsey from the hospital information shared with them was that Mr. Ramsey was a chronic alcohol and drug abuser who was acting as he was so that he might obtain drugs. No other concerns and no other information were communicated to the attending members. Armed with this knowledge and information, the RCMP officers treated Mr. Ramsey appropriately and within RCMP policy regarding his arrest and detention. Use of the restraint chair was within the RCMP policy and the officers involved handled Mr. Ramsey as their training and the guidelines required. Mr. Ramsey was properly monitored pursuant to RCMP policy and guidelines.

Notwithstanding the fact that health care providers and RCMP members and guards acted as required by general medical standards and official RCMP policy, Mr. Ramsey fell seriously ill and did not recover. The only logical conclusion therefore is that improvements to the approach currently followed are required to seek to prevent deaths in similar circumstances in the future.

Recommendations for the prevention of similar deaths:

Effective and complete communication is among the most important factors relating to the handing over of responsibility from one party to another. This is so in relation to countless matters including the transfer of responsibility for a person from a hospital to the RCMP. Communication in this case was limited to the transfer of information that Mr. Ramsey was a chronic alcoholic and drug abuser who was acting out so that he might secure narcotics. This is not surprising having regard to the facts gathered from Fairview Health Complex regarding Mr. Ramsey's history. However, information regarding concerns related to Mr. Ramsey's prognosis was not passed to the RCMP officers. This was relevant information that could have been used by members in assessing optimal alternatives for the handling of Mr. Ramsey.

Recommendation: It is recommended that as a matter of policy RCMP officers who take responsibility for an individual from health care providers obtain from the health care providers a brief written summary regarding health issues, concerns and prognosis for the individual.

RCMP officers and detachment matrons and guards are not likely to be trained medical care providers. They are not doctors, nurses, emergency medical technicians or other health care providers trained in diagnosing medical issues. They are, like most of us, able to react appropriately when a medical emergency presents itself. However, it seems unfair to expect our front line officers and personnel to recognize the possibility of consequences as drastic as occurred in this case when Mr. Ramsey's behaviors did not change from the time he was medically discharged from the hospital to the time of his distress in cells. It is reasonable, in my view, to require medical intervention as a matter of policy when circumstances such as occurred here exist. In cases where an individual's behavior remains agitated, incoherent, and bizarre for an extended period of time such that continued use of restraint devices is required, a time should come when further medical or psychological assessment by trained health care providers is sought. It is reasonable to consider such time to be that which has been recommended by the manufacturer of the device used in this case. This is so, not because of concerns about the use of the restraint devices, in this case an Emergency Restraint Chair, but rather because constant bizarre behaviors should signal a need for concern for the well being of the individual.

Recommendation: It is recommended that as a matter of RCMP policy no person shall remain in a restraint chair or device longer than two hours without assessment by a trained health care provider and direct medical supervision, if such assessment determines that to be required.

DATED August 27, 2010,

at Peace River, Alberta.

G. William Paul

A Judge of the Provincial Court of Alberta