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

on the 28th day of May, 2009 (year), (and by adjournment

on the 29th day of May, 2009 (year)),

before The Honourable R. A. Jacobson, a Provincial Court Judge,

into the death of SYDNEY JAMES SALTER (Name in Full) 88 (Age)

of #122, The View, 110 Scenic Drive North, Lethbridge (Residence) and the following findings were made:

Date and Time of Death: December 31st, 2007

Place: Parking Lot Outside, The View, 110 Scenic Drive North, Lethbridge, Alberta

Medical Cause of Death:
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 Inquires Act, Section 1(d)).

a. Hypothermia Due to Cold Exposure
b. Dementia Secondary to Ischemic Cerebrovascular Disease
c. Severe Generalized Atherosclerosis

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

Accidental

Circumstances under which Death occurred:

See Attached

Recommendations for the prevention of similar deaths:

See Attached

DATED July 29th, 2009,

at Lethbridge, Alberta.

A Judge of the Provincial Court of Alberta

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Circumstances under which Death occurred

[1] Sydney Salter was a resident of The View Holiday Retirement Home ("The View") in Lethbridge, Alberta, a private, independent living facility. It was primarily a senior's residence which offered cleaning and meal assistance. On January 21st, 2008, Marlena Standley, Assistant Risk Manager for the Holiday Retirement Corporation, prepared an Incident/Accident Report for Facility Number 5360, The View. The incident was described as follows:

> Sydney Salter was found dead in the community parking lot 12/31/07. Cause of death was assumed to be exposure. The incident was not reported to Risk Management. Nina Buchanan heard about this from Resident Relations. Nina reported to Marlena Standley 1/21/08. Marlena called the facility and interviewed Judi Cochlan, Manager. Investigated by Lethbridge Police (see email for more detail).

[2] Attached to the Incident/Accident Report was a page of handwritten notes which contains the handwriting of various individuals. The first entry for Monday, December 31, 2007,states:

> Sidney missing @ breakfast checked room empty found clothes in exit returned to room 8:15 a [sic]. Resident Peter Huising found him in parking lot. Called 911 around @8:45 with police Tom phoned Michaels [sic] home L/M then I phoned Michael's cell told him we'd called 911 didn't think he survived the nite [sic]. Police & amb. arrived he did not survive. Phoned Karen let her know. Tom phoned Michael back. D.O.A. Snowed in night Temp in a.m -15C.

[3] At the time of his passing, Mr. Salter was receiving care assistance from We Care Home Health Services. The purpose of the service was to assist him with his laundry, provide companionship, remind him to take his medications, and assist him in settling at night.

[4] Constable Darby of the Lethbridge Police was the primary police investigator. When he arrived on the morning of December 31st, the ambulance was already at the scene. Mr. Salter's body was lying with his back on the sidewalk approximately 100 yards southeast of The View, at the parking lot.

[5] The main entrance faces southwest. Cst. Darby assumed Mr. Salter had lain on the sidewalk before 2:00 a.m. There had been a light snowfall between 2:00 a.m. and 7:00 a.m. that left a "light dusting" of snow in the area and over Mr. Salter's body.

[6] Footprints in the snow were consistent with those who were or had been at the scene. There was no evidence of foul play. Mr. Salter was still wearing his wrist watch.

[7] There were some abrasions and some blotches of blood on Mr. Salter's big toes and the back of his right hand. Cst. Darby felt that these abrasions were consistent with him trying to crawl. There is no evidence that establishes how Mr. Salter ended up lying on his back on the sidewalk, nor that he had attempted to crawl any distance. There are different possibilities. Mr. Salter may have lost his balance and fell; stumbled and fell; collapsed; or laid down due to exhaustion and fatigue:

a. he did not have his walker;
b. he had difficulty walking;
c. he tired easily;
d. he may have been disoriented.

[8] Dean Goerzen was the medical investigator. At 11:09 a.m. on December 31, he spoke to Cst. Darby and Tom Cochlan, one of the managers at The View. Mr. Cochlan identified Mr. Salter's body. It was determined from Eve Green (since deceased) that she saw Mr. Salter between 6:30 and 7:00 p.m. on December 30, 2007. Mr. Goerzen prepared the Investigator's Report of Death. The beginning states:

> Notified of death of 88 year old man found dead on sidewalk outside of apt building in which he resided alone. Body partially frozen and not dressed for being outside in cold weather (shirt and light pants only, barefoot - no jacket). A neighbor reports she saw decedent walking around in inside common hallway of building about 1900hrs Dec 30/07. Decedent stated he was "looking for his walker". Decedent had no shoes or sox [sic] on at this time. (Walker was found by LCP member in middle of floor inside decedent's suite - suggests decedent was confused).
>
> Neighbor (and building manager) Tom Cochlan discovered body am Dec 31/07. It snowed at this location between 0200-0700hrs Dec 31/07. Body covered by small amount of fresh snow, no evidence of tracks or foot prints in fresh snow. No signs of injury to body but for small amount of blood at toe nails? c/w decedent crawling along rough ground while barefoot.
>
> Decedent's jacket, wallet and keys were found in lobby of building, neatly stowed. Lobby door is not locked so decedent was NOT locked out of building.
>
> Decedent's front door to his suite was closed but not locked, rear door was locked. Decedent lives on opposite end of building from where body was found so decedent had to have walked halfway around building before reaching place where body was found. No evidence of liquor or cigarettes or drugs in suite. Suite neatly kept.
>
> Tom Cochlan called decedent's son in Arizona and notified him of death. OCME has not yet talked to son. PRD coming. Body going to LRH via Martin Bros FH for exam under Dr. MacKay. Dr. MacKay accepted case, admitting aware.

[9] The report states that the investigator did not attend the scene, and that he learned from Mr. Salter's neighbours that he had been suffering from Alzheimer's Dementia. The nurse for Mr. Salter's family physician confirmed this. According to the report, she also stated that Mr. Salter had "several episodes of nocturnal wandering in the past".

[10] These are the circumstances of Mr. Salter's death. One may question how an elderly man suffering from dementia, allegedly with several past episodes of nocturnal wandering, was still living in a private facility which did not provide health care services. In order to answer this question, one must examine how Mr. Salter came to be a resident of The View and how his medical situation changed during the time he lived there. When one examines this background, it becomes apparent that the situation was not as black-and-white as the circumstances of his death may make it appear.

The Background to the Death

[11] At the time of Mr. Salter's death, two couples were employed by the Holiday Retirement Corporation as building managers for The View: Alvin and Wilma Strand, and Tom and Judi Cochlan.

[12] The evidence of Alvin and Wilma Strand, now of Creston, British Columbia, was provided by affidavit. They referred to themselves as "floating" building managers for The View. The managers served 24 hour shifts from 6:00 a.m. to 6:00 a.m. the following day. Their responsibilities included overseeing all other staff, managing the office, and responding to any emergencies or any other matters brought to their attention by staff or residents.

[13] Staff at The View provided maintenance, housekeeping, transportation and meal preparation. Residents normally receive their meals in a common dining room. In cases of short-term illness, meals could be delivered to residents in their rooms.

[14] It was also the managers' responsibility to ensure that all three doors were locked at 8:00 p.m. each evening. Then they would close the office and retire to their dedicated residence within The View. From that time on they were on call to residents for the remainder of the manager's shift from 8:00 p.m. to 6:00 a.m.

[15] The Strands gave the following description of the building:

a. The View is a three-storey high apartment facility, with two main exit doors to the outside, and one additional door that was not used as frequently.

b. Each evening all exit doors were automatically locked at 8:00 p.m. Except for the main door this action prevents access from the outside but someone inside could open the door to exit.

c. Residents had a key to enter through the main door. If they forgot their key, or if a non-resident wished to enter after 8:00 p.m. that person could push a button and speak to a manager through the intercom. Then the manager could grant access through the main door from controls within the office.

[16] The Strands knew and conversed with Mr. Salter since he was a resident. In the Strands' experience, "Mr. Salter would normally be able to attend the common dining area for his meals".

[17] The View had "no responsibility for overseeing" or providing health care or personal services. Residents hired their own care staff from outside agencies, as required. The Strands were aware that Mr. Salter was receiving "some form of care services" from We Care, an outside agency. These "support services" included laundry and a "turn down service following supper".

[18] On the day prior to Mr. Salter's death the Strands had one lengthy conversation, and perhaps other conversations, with Mr. Salter. At these times Mr. Salter "appeared to be very confused".

[19] The Strands worked the 6:00 a.m. to 6:00 a.m. shift on December 30th/31st, 2007. They were in the manager's office during the day. That evening the Strands recall closing the office at approximately 8:00 p.m., locking the three exit doors, and retiring to their residence within

The View. They do not recall receiving any emergency calls nor any notification that Mr. Salter was encountering any problems that required their assistance.

[20] At 6:00 a.m. they turned over the responsibilities of building manager to Tom Cochlan and then they left. They "were not aware of any problems involving Mr. Salter, nor were [they] aware that he had left the building". Later they learned of his death.

[21] The Strands "never personally observed" any incidents of Mr. Salter wandering outside the building, however they:

> Did hear from other people, we cannot recall who, that there may have been such an incident or incidents in the past. We cannot recall or were never aware of any details about any such incident or incidents.

[22] Of the other two building managers,Tom Cochlan and Judi Cochlan, only Mr. Cochlan gave evidence. He had no prior experience as a building manager before he commenced training in Oregon and then had intensive on job training at The View after it opened in December 2001.

[23] Mr. Cochlan testified that the managers worked two days on, two days off. The couples each had their own private, dedicated suite within The View where they lived full time. They did not have to remain at The View except when on duty.

[24] Mr. Cochlan described The View as an independent living facility. The 144 residents of the View were independent and could come and go as they chose.

[25] Mr. Cochlan stated that The View did not provide health care. There were various health problems in the facilities "at the time". Residents who needed care, at their own expense, made their own individual arrangements with caregivers. Although Mr. Cochlan discussed health concerns with residents and their families, especially Mr. Salter's son Michael, he did not get too involved. He was sensitive to privacy. It was important that he not "overstep" his bounds. There was a "fine line" as to contact with caregivers. The managers were not authorized to go directly to healthcare since the managers were not qualified to assess needs. That did not preclude daily contact with We Care and speaking to them from time to time.

[26] Mr. Cochlan considered Mr. Salter to be a "dear friend" who often came to the office to talk. These visits became more frequent, and there appeared to be a little more confusion. The Cochlans and Michael maintained close telephone contact concerning Mr. Salter's condition. Michael mentioned testing and possible relocation for his father.

[27] The office was officially open daily from 7:00 a.m. to 7:00 p.m. In practice Mr. Cochlan was busy from 6:00 a.m. "and on" because of remote phones. At 7:00 p.m. he would close the office, check the kitchen, speak to the chef, and confirm that the exit doors were secure. The automatic front doors were inspected periodically. There had not been any problems. Afterwards, he would switch the phones to his suite, and take calls, if any, as well as respond to emergency calls, and assist residents to re-enter when they had forgotten their keys. To Mr. Cochlan's knowledge this system never failed.

[28] Mr. Cochlan did not have personal knowledge nor was he aware of any specific facts that Mr. Salter had wandered, "but residents may have mentioned it". He doesn't recall taking meals to Mr. Salter, but he had successfully encouraged him to come to the dining room.

[29] Mr. Salter often went to the patio but he had no problems with the door to his room nor with the front door. At the office visits, Mr. Cochlan noticed that Mr. Salter was becoming more

confused and belligerent. Mr. Salter wanted more time spent with him. He stated to other residents that he didn't know where he was. He was confused, but when offered assistance on one occasion, angrily replied, "Leave me alone, I know where my room is!"

[30] On Monday morning, December 31, 2007 at 6:00 a.m., Mr. Cochlan commenced the day's shift. He switched the phones to his suite, went to the kitchen and checked with the chef. Then he returned to his quarters and had breakfast at 8:00 a.m. Up to this point nothing appeared to be out of the ordinary.

[31] Shortly afterwards he found Mr. Salter's belongings neatly stacked in the back foyer. Mr. Cochlan and his wife took them to, and entered Mr. Salter's room. The front door was unlocked. Then the couple started a building search.

[32] Mr. Huising entered the building and said he thought that he had found a body. Mr. Cochlan went outside and confirmed the findings and noted the footprints of Mr. Huising and Mr. Salter. He returned to the office and called 911. He spent most of the morning with the police.

[33] We Care Home Health Services was providing assistance to Mr. Salter from October of 2007 to the time of his passing. Cindy Malitowski, the President and CEO of the We Care Home Health Services franchise in Lethbridge, testified at the Inquiry.

[34] Ms. Malitowski stated the franchise had the same boundaries as the Chinook Health Region. We Care provided private home care at all levels, from companionship and meals to licensed practical nursing (LPN) and registered nursing (RN) services, 24 hours a day, 7 days a week. We Care also obtained contracts for facilities.

[35] Policies from intake to discharge were set by the corporation's headquarters in Toronto. We Care emphasized that it had "earned an unconditional three year accreditation from the Canadian Council on Health Services Accreditation". This accreditation process is described as follows:

> The Accreditation Canada is a non-profit, non-governmental organization, which is responsible for the accreditation of hospitals, nursing homes, and other health care facilities and organizations, throughout Canada. Its mission is to promote excellence and the provision of quality health care, and the efficient use of resources, within Canada's health care system.

[36] On October 1, 2007, Michael Salter, Mr. Salter's son, contacted We Care to arrange for Home Support Companionship Services for two hours, Monday to Friday, for his father. This was not an Alzheimer's program and no medical services were provided. The Service Requisition dated October 1, 2007 includes the following information:

> **General Medical Information**
>
> Moved to the View in April 2007. Occasionally gets calls about Dad not making it to meals or not showering in the morning.
> Some issues with washing his clothes.
> *Retinal detachment Rt eye
> Assess and notify son of Recommendations
> Client loves to play crib, they have a crib night @ The View, loved to play golf, reading (Economist)

[37] The document was signed, but the author is unknown.

[38] A We Care Client Assessment is dated October 2, 2007. It states the attending physician was Dr. Melling. There is no record of when Dr. Melling ceased to be Mr. Salter's attending physician and when Dr. Dong assumed responsibility. Dr. Dong was Mr. Salter's physician at the time of Mr. Salter's death.

[39] The Client Assessment contains the following relevant information:

> Diagnosis: According to son "possible dementia"
>
> Medical Surgery History: Fractured hip four years ago. Fell off a chair in the home.
> Client is a poor historian
>
> Social History: Son Michael lives in Phoenix, Arizona… no family in Lethbridge...
> …most friends are deceased.
>
> Other Services Providers: None
>
> **Respiratory**: No difficulty
> Breath sounds clear
> Comments: While sitting and talking at times client seems to have some shortness of breath. However when asked about it – client denies any problems or concerns.
>
> **Musculoskeletal/Ambulation**
> Aides: Type Walker
> Comments: Ambulates with walker. Sometimes confused and unsteady on his feet.
>
> **Neurologic/Speech:** No difficulty
> Comments: Client reports no difficulty. Client is at times disoriented and needs re-direction. However, client responds well to re-direction and acknowledges he needs assistance.
>
> **Psychological:** Oriented to person
> Feelings of hopelessness
> Distrustful/unable to relate
> Comments: Client admits to feeling incredibly depressed @ times.
>
> **Sleep Patterns**
> Comments: Sleeps most of the day and night. Client reports he does not know why.
>
> **Medications**: None

[40] A Fall Risk Assessment was also completed by an unknown person on October 2, 2007. According to this document, Mr. Salter reported that he had not fallen in the past 3 months, and that he did not have episodes of dizziness, a seizure disorder, or difficulty getting out of bed or a chair. Mr. Salter reported some difficulty walking.

[41] The Assessment also stated that Mr. Salter exhibited confusion, disorientation, decreased mobility, disturbance in gait or balance, and decreased visual or hearing ability, but

that he did not exhibit effects of sedation or restlessness. Mr. Salter reported that he was not taking any medication.

[42] The Fall Risk Assessment also posed the question, " Does the client have an illness or disease that may cause a fall?". This question was answered:

> Uses a walker for ambulation. Somewhat confused and disoriented at times. Oriented to person only.

[43] On October 2, 2007, Mr. Salter signed consent forms which authorized We Care to render home health services to him, and gave We Care the right to provide Mr. Salter with medical treatment that We Care deemed advisable. Mr. Salter retained the right to refuse the treatment. The consent forms also authorized We Care to obtain his medical records and release them to his son.

[44] After We Care started providing services, a Home Health Living Client Profile Report included the following comments:

a. THE CLIENT IS NOT ABLE TO MANAGE LAUNDRY INDEPENDENTLY
Considering the client has been significantly confused and not able to recall when his laundry has been done last and who has been doing it, it is imperative that we check the laundry…. This must be done with discretion and compassion.

b. CLIENT MISSING MEALS DUE TO MEMORY ISSUES AND EXCESSIVE DAYTIME SLEEPING.

1. Post a calendar in each room on the home to keep the client oriented to the date. Investigate the possibility of setting alarm clock to alert client of meal times. Post a sign with reminder times of meals in the client's home.

2. With the client's assistance, create a day time routine that is written and posted in his room. May want to even involve the client's son in the beginning to have him telephone the client at a certain time to alert the client that it is time for a particular meal. Or it may be appropriate to ask the office staff at The View to provide a wake-up call or knock on the door to alert the client of a certain meal or activity that the client is supposed to attend.

3. Keep some snack foods in the client's room on hand in the event that the client miss a meal.

[45] Ms. Malitowski was referred to the medical investigator's (Mr. Goerzen) Continuation Notes, where he recorded that Mr. Salter was found wandering between 0300 – 0600 hours on Oct. 22. She stated that the manager at The View informed We Care on October 22 that Mr. Salter was found wandering on October 21. We Care spoke to Mr. Salter's daughter-in-law who authorized two 12 hour night shifts: Michael asked for an assessment.

[46] Ms. Malitowski stated that by December, Alberta Health Services (Home Care) was in control. This came about as a result of Michael Salter's request for an assessment in the later part of October, 2007. We Care was not involved in the medical assessment process except to respond to telephone inquiries.

[47] Ms. Malitowski testified that We Care's contract was expanded for a short term while Health Services determined where Mr. Salter would live. We Care knew he was confused.

[48] From the documentation, it appears that Alberta Health Services Home Care was involved with Mr. Salter's care by November. A fax from Joy Dykslag of the Chinook Health Region was sent to We Care on November 16, 2007, requesting that We Care assist Mr. Salter in getting to doctors' appointments with Dr. Dong on November 19th and Dr. Ikuto on November 26th.

[49] Ms. Malitowski confirmed that We Care was closed December 22 to 26, then 29 and 30. There is no record at any time of outgoing phone calls.

[50] Two We Care employees who provided care to Mr. Salter testified at the Inquiry.

[51] Linda Ransome is a health care aide who specializes in seniors and the disabled. Working on and off she completed a 6 month course as a 1989 graduate of Mohawk College, Ontario. She studied diseases, seniors and disabled. She is familiar with dementia and Alzheimer's.

[52] Under the Care Plan created by We Care, she provided "mostly companionship". Initially Mr. Salter suffered depression from the loss of his wife. Later he seemed disoriented and genuinely confused. He asked questions such as: Where was he? Why was he here? Ms. Ransome advised We Care. Then the health nurse from Alberta Health Services, Joy Dykslag, came in "with their own protocol". Ms. Ransome recalled the specifics of conversations between Mr. Salter and herself. She felt that his behavour as indicated by the ways he would come and go "were sort of warning signs".

[53] On December 17th Mr. Salter went shopping and had supper with his son. Then he went with Ms. Ransome to listen to Christmas music.

[54] On December 18th Mr. Salter started taking his new medication.

[55] On December 27th Ms. Ransome did two shifts, first from 11:00 a.m. to 1:00 p.m. and the second from 6:00 p.m. to 8:00 p.m.

[56] Ms. Ransome found him to be confused. The manager spoke to her and advised that Mr. Salter was confused: that he didn't know where he was and that he had his TV too loud, resulting in the neighbours complaining. She noted Mr. Salter needed to take his medication.

[57] During the second shift Mr. Salter was already in bed. He said he was tired. She told him to keep his TV down for the evening.

[58] Between 11:00 a.m. and 1:00 p.m. on December 28th, Mr. Salter went for a walk, had a shower and had lunch. Ms. Ransome appears to have remained from 1:00 to 3:00 p.m. On both occasions she noted on the Flow Sheet that Mr. Salter was "C/O – confused/oriented". His condition varied during the shift. He frequently complained of tiredness.

[59] On December 29th, Ms. Ransome was present from 1:00 p.m. to 3:00 p.m. She did laundry and reminded Mr. Salter to take his pills. He was "tired, just wanted to lay down".

[60] Ms. Ransome did not contact anyone except We Care concerning Mr. Salter. We Care had previously told her of nocturnal wandering that occurred on October 22nd and it was for that reason We Care had to get attendants for night shifts. She did not observe any wandering.

[61] Throughout the months Mr. Salter needed more care, he was depressed, and expressed that he wanted to be with his wife, and that he didn't care. He didn't know where he was. Ms. Ransome knew he had seen a doctor and that Health Services was considering a move.

[62] Ms. Ransome was not involved in the initial We Care intake and assessment. That was done by We Care management, who then came to her with the care plan. She was to provide care, not treatment, e.g. companionship and laundry, and was to remind Mr. Salter about meals and medication. If specific attention was required outside assistance was called in. She guessed that management would look into it. She could not recall with certainty if she contacted We Care between December 24 and 28, 2007 but she stated she knew We Care was aware of Mr. Salter's condition.

[63] Linda M. Carlson had worked for one year in an independent living facility before starting with We Care as a part-time care attendant in August 2007. She is not a nurse and did not take specific training for her position. From her own family situation and through self education she had some knowledge of dementia and stages of depression.

[64] She participated in preparing We Care Client Program Notes, which were tendered as evidence. Also during each shift she kept records in a blue duotang of "what has been done…what needs to be done…and who was contacted…" This information was for the benefit of the next person to come on shift. At the end of the month the duotangs were collected and sent to head office. The duotangs were not tendered as evidence.

[65] Ms. Carlson was to provide "light care" including laundry, monitoring aspects of daily living, leaving clothes out, walking with Mr. Salter, assisting Mr. Salter to take showers, and reminding him to take medication because he had some memory problems. She was not responsible for giving him medicine. Except for his laundry she felt Mr. Salter was quite capable on his own.

[66] Ms. Carlson was with Mr. Salter for approximately "two or three months", on average one to two days on weekends. The full time "nurse" was Linda Ransome. There were other part-time care attendants.

[67] Ms. Carlson recalled that during her 6:20 to 8:20 p.m. shift on December 16, 2007, Mr. Salter had supper with his son. There were lengthy conversations. There was no indication of Mr. Salter leaving, but he expressed extreme loneliness and grief. He wished that his son and grandchildren didn't live so far away. Michael was aware of the depression. He also discussed Alzheimer's with Ms. Carlson.

[68] When she first started, Ms. Carlson was informed that Mr. Salter was confused and given to angry outbursts. She did not find this to be so. He was witty and wise. Occasionally she found him outside his room.

[69] In Ms. Carlson's opinion, the deterioration in Mr. Salter's condition was not obvious. However, by December his behaviour was changing, although on December 19th he listened to "Band Entertainment" and was in a good mood. In contrast, on December 29th during the 6:30 to 8:30 p.m.shift she described him as "quite confused" when she arrived and he seemed to be "confused all evening". He would not change or get ready for bed. When Ms. Carlson left he was lying on the bed fully clothed and said that he would see her tomorrow. She doesn't know if he was asleep when she left – she took a chance that he was asleep.

[70] On Sunday, December 30, 2007, Ms. Carlson worked two shifts:

a. 1:00 to 3:00 p.m.

b. 6:15 to 8:15 p.m.

[71] During the first shift she noted that there were no medications. She unsuccessfully attempted to call the pharmacy – it must have been closed. She stripped the bed and accompanied Mr. Salter on a drive and then a walk. He was confused. The second shift was difficult, and he was very confused. Ms. Carlson's Client Progress Report Notes for December 30th state as follows:

1-3	Client was eating lunch on arrival. There is no more meds. for Client phoned Skelton's Pharmacy but they must be closed on Sundays. Stripped bed and washed bedding. Took client for drive went for a little walk.
6:15-8:15	Client was at supper when staff came. Would not take a shower but changed into his PJ's and brushed his teeth. Staff went out to throw clothes in laundry. Lady who sits at client's table came to tell me Sydney was wandering down the hall in his pajamas. He was going towards the dining area without his walker. Client had his shoes, pill box & wallet & keys in his arms. When asked where he was going he said nowhere. Took him back to apartment and put the stuff away. Explained that he could not wander about in his PJ's. Client stated that it was his home and he could go out. Told client he should change into his clothes and we could go for a walk. He did not want to do this. Put music on for client, went back to laundry room. When staff came out client again wandering out in bare feet no walker, out by dining room. Tried to get him to come back to apartment – No go. Got his walker and we walked to the other side of the building and back.

[72] There was no protocol to alert anyone about Mr. Salter's wandering. Ms. Carlson did not phone Michael, nor contact anyone.

[73] Ms. Carlson couldn't recall the details of a prior occasion when she believes that Alvin Strand told her that Mr. Salter had wandered before and someone let him in. He may have told her that it was because of the wandering that We Care was there.

[74] Ms. Ransome stated that the health nurse, Joy Dkyslag, came into the situation "with [her] own protocol", and Ms. Malitowski testified that by December, Alberta Health Services (Home Care) was in control. It appears that both Ms. Ransome and Ms. Malitowski were referring to the public health care system, namely, Alberta Health Services Home Care. Colin Zieber was called to "explain the system".

[75] Mr. Zieber has a Master's Degree and is a Registered Psychiatric Nurse. He is with Alberta Health Services Management as co-director of senior's health at Lethbridge Regional Hospital.

[76] Mr. Zieber stated the first step is the Access Centre, which is the single point of entry to the continuing care system. When an individual is referred to community care or home-based care services, the initial referral flows through the Access Centre. The individual is registered, and is then assigned to one of the community care case manager nurses. The community care case manager then does their assessment and determines what the client needs. There are many options, one of which is referral of the patient to the hospital's geriatric team.

[77] After assessment, if the client needs to be considered for facility-based care, the case is presented at a meeting called the Living Options Committee. A summary of the health information is presented by the community care case manager, and the needs and desires of the client are considered on a triage basis. Generally, a recommendation is presented to the committee, which then determines what it feels is the most appropriate level of care for the client. The health system will then support the client going into a facility that has the recommended level of care.

[78] Many of the witnesses who testified spoke of the various types of facilities that are available to provide a continuum of care options. Caution must be taken when the term "assisted living" is used, as it is often a generic term covering a variety of care options. Generally the various levels of care are as follows:

a. a private independent living apartment with cleaning and meal assistance: This is the type of service provided at The View. Mr. Salter was receiving additional assistance through the private purchase of additional care from We Care.
b. enhanced care or enhanced lodge (EL): These facilities provide 24 hour, unscheduled care. For example, if someone needs assistance going to the washroom or taking medication, someone is on call to assist them. The expectation is the individual is able to call for help and communicate what they need. Generally there is only one caregiver on call at a time, so if the individual needs more than one person to assist with movement, they need a greater level of care.
c. designated assisted living (DAL): these facilities provide 24 hour personnel and an LPN. This type of care permits for greater evaluation. For example, if an individual needs pain medication in the middle of the night, it can be provided. There is also more than one person to provide care at a time. DAL also have special cottages to maintain clients with Alzheimer's or dementia that need to be in a secured facility.
d. continuing or long term care: For persons with unstable medical or mental conditions that require a registered nurse to be on duty 24 hours per day to maintain the client.

[79] When a client goes from home-based services to being considered for facility-based care, the Access Centre is involved in ensuring the information is correct and eventually passed to the right facility. It is responsible for coordinating communication between the client, the family, the nurse, and the facility. It is the conduit point for information across the whole continuum of senior's services.

[80] The roles and responsibilities of the community care case manager nurses, physicians, nursing unit managers (acute care), transition teams, and facility managers or designates, as well as the role of the Access Centre and Living Option Meeting, are found in Exhibit F1, Tab 17, "Living Options Referral Process Roles & Responsibilities".

[81] The Living Options Referral Process Roles & Responsibilities states the following responsibilities for the Access Centre:

1. Schedule presentations for appropriate Living Options Meetings.
2. Prepare and distribute agendas for Living Options Meetings and receive Living Option Summary Forms and CAPs report for clients being presented.
3. Chair Living Option Meetings.
4. Ensure clients are prioritized at the Living Options Meeting according to need/urgency for available beds.

5. Waitlist clients for appropriate living option (EL, DAL, Continuing Care) within 24 hours following the Living Options Meeting.
6. When client is in hospital, Access Centre will send letters regarding initiation of Living Option charges to client/family via mail and to Nursing Unit Manager, Physician, Social Work Department, Discharge Department or Admitting Department, Finance Department and Community Care via fax within 24 working hours of decision to waitlist.
7. Keep relevant statistics on databases related to placement process.
8. **For Continuing Care/Designated Assisted Living Options**:
    - Track living option bed availability.
    - Fax Living Option Summary/Caselog, Care Plan and demographics to Continuing Care/DAL facility when a bed becomes available. …
    - Contact Community Care Case Manager/Care Planning Consultant regarding a bed available for the client.
    - Once the date and time of admission is arranged, Access Centre will notify the Nursing Unit, Physician and Community Care Case Manager/Care Planning Consultant.
    - Complete the admission by filling in admission date on client's file and the Continuing Care/DAL database.
9. **For Enhanced Lodge Options**:
    - Track bed availability.
    - Fax EL application to the Administrator.
    - Once an admission date is provided to the Access Centre, they will fax the EL referral with the admission date to the appropriate EL Community Care Case Manager.
    - Complete the admission by filling in admission date on client's file and the Enhanced Lodge database.
10. Track First Available Bed Transfer list and arrange client transfers when the first choice becomes available.

[82] Once being referred to a new client, the role of the community care case manager nurse is to do the following:

Prior to presentation at Living Options Meeting:

1. Complete an assessment of the client using MDS-HC 2.0.
2. Request OT/PT, Social Work or other discipline assessments as required.
3. Review appropriateness of client going home by exploring all community options. [A list of options is given, but has been omitted.]
4. Complete required documentation (see checklists) for living option placement **WITHIN 14 DAYS** of receiving the request for living option placement.
5. Discuss finances with the client/family, including the following in the discussion. [list has been omitted]
6. Initial discussion of first available bed policy.
7. Arrange case conferencing with the assistance of Transition Team as required.

[83] As noted in the above summary, if a request is made for a living option placement, the community care case manager is to complete the required documentation within 14 days of the

request. Also within the 14-day period, the community care case manager is to contact the Access Centre to book a presentation on the Living Options agenda. Within 24 hours following the Living Options Meeting, the community care case manager is to discuss the decision and available options with the family.

[84] Using the triage method the Living Options Committee considers the information provided to balance the needs and determine where the individual best fits. Based on the assessment and where the needs are within the guidelines, care is provided accordingly. If competent, the client makes the ultimate decision.

[85] If facility-based care is recommended, another policy exists for placement. This policy is located in Exhibit F1, Tab 16, "First Available Bed for Placement of Continuing Care Clients Waiting for Urgent Placement from the Community or from an Acute Care Hospital Bed within the Chinook Health Region". The protocol is for the individual to take the first bed and then get to the preferred location as soon as possible. The following are the specifics of the protocol. The steps to be taken when a client, guardian or physician refuses to consent have been omitted:

1. POLICY

    1.1 A client assessed as requiring urgent placement into a Continuing Care facility bed, will be offered the 'first available and suitable bed' within a sixty kilometer radius of their facility of choice. The client may come from the community or from an acute care facility bed within the Chinook Health Region.

    1.2 Suitable refers to client specific needs and facility capabilities i.e. cognitively impaired persons may require a secure environment; continuing care clients with palliative care needs may be best served in the client's community only.

    1.3 A client who has been admitted to a Continuing Care facility outside his/her community of choice, will be offered a Continuing Care bed in the facility of his or her choice when one becomes available.

    1.4 A 'transfer list', using the date of admission, will be maintained and transfers back to the facility of choice will be given first priority over new admissions to Continuing Care facilities.

2. OUTCOME:

    2.1 Appropriate client/resident placement.

    2.2 Urgent placements accommodated in a suitable facility.

3. PROCEDURE:

    3.1 Using a recognized process for assessment, appropriate personnel from the Community Care program will assess the

client. Such assessment will consider client specific needs as well as identify significant resources already contributing to the care of the client (e.g. presence or absence of family members).

3.2 Provide the client and family with information regarding all realistic options and relevant Chinook Health Region policies. This information is usually provided by the Community Care nurse but may also be provided by a Program Director where it is apparent that further information is required to facilitate placement.

Admission

3.3 Central Placement personnel will notify the client/family/guardian, the Community Care Program, the Continuing Care Unit Manager of the facility to which the client has been assigned, and the family physician when a Continuing Care bed is available.

[86] Once a facility is chosen and a bed becomes available, the Living Options Referral Process Roles & Responsibilities gives the following responsibilities for the Facility Manager or Designate:

1. Approves admission of the client within 48 hours following receipt of information from the Access Centre.

2. Notifies Access Centre of admission date within 24 hours of approving admission.

3. Responsible to contact the client/family and offer the bed unless instructed by Access Centre.

4. Provide pre-admission tour and conference to client/family prior to admission date.

5. Discuss with client/family prior to admission:
   - Physician information/problem solving if client's physician does not have admitting privileges at admitting facility.
   - Empowering family with information as to transportation of client to facility, personal belongings, type and amount of clothing, labeling of clothing, finances and furniture.
   - Contact Community Care Case Manager if further information is required.

[87] Until the third week of October of 2007, Mr. Salter was not involved in the public health continuing care system described by Mr. Zieber, and was simply receiving private care from We Care. The continuing care system was triggered after October 22, 2007, when We Care was informed that Mr. Salter was found wandering on October 21st . Mr. Salter's son Michael requested an assessment.

[88] Joy Dykslag was the community care case manager to whom Mr. Salter was assigned. She graduated from Lethbridge Community College in 1989 as a Registered Nurse. Her whole

career has been with Chinook Health. Her first position was on a cardiac floor at Chinook Regional Hospital. After 16 years she went to Home Care.

[89] In November and December, 2007, her duties as community case manager were to manage a caseload of 50-60 clients. She would monitor how they were doing, but not necessarily on a daily basis. She would see some every day, others up to every 3 months, depending on the needs of the client. She would see a new referral within days of receiving the notice. Usually she would contact a new client by telephone and make an appointment to see them. She responded to her client's calls for equipment, if they were feeling unwell, etc. She would also respond to calls from Grey Stokes or Lethbridge Family Services, who would call if their care givers had concerns about what they had seen in the home. She would assess services to see if they needed to be increased.

[90] Ms. Dykslag believes, but isn't sure, that the original referral was from Mr. Salter's son. Her first involvement with Mr. Salter was around October 24th. She may have seen him October 27th, but would need to see her documentation. She understood that he was referred because of concerns with wandering, specifically, that he had been wandering at night outside his apartment. She was aware that he was already receiving private care through We Care, paid for by his family.

[91] As a first step she visited and did a preliminary assessment of Mr. Salter. After her initial assessment on October 27th, Ms. Dykslag felt he needed further assessment. So she spoke with Colleen Jones, an R.N. who worked with Dr. Ikuta, a local geriatrician.

[92] Ms. Dykslag wanted a geriatrician to see Mr. Salter and that is why she made the referral to Ms. Jones. She knew this was a quicker way to get a patient into a geriatrician than making a geriatric appointment.

[93] Ms. Dykslag was referred to two documents entitled, "Client's MDS-HC Assessment", numbered 0001 and 0002. Both were for Mr. Salter, and prepared by Ms. Dykslag. One was completed on November 16, 2007, and the other on December 4, 2007. Both represented a complete package of her assessment of Mr. Salter as of the given date. The information was available to the rest of the assessing team.

[94] The primary purpose of the MDS-HC Assessment is to constitute the assessing form for community care. It assesses all aspects of the individual, including areas such as physical and social functioning, vision, mood and behaviour patterns, diseases, depression, and cognitive abilities, all in one "handy place".

[95] When Ms. Dykslag prepared the assessment dated November 16, 2007, it stated:

- client has moved to The View recently and has wandered outside in the middle of the night and has had to ring the manager to get back in the building.
- wandering – moved with no rational purpose. Seemingly oblivious to his needs or safety.

[96] The assessment contained the following findings:

a. With respect to 'cognitive abilities', she found Mr. Salter's short-term memory was a problem.
b. The category "procedural memory" means things like getting up in the morning and knowing to wash up, without someone there to cue the individual along. Ms. Dykslag assessed Ms. Salter's

procedural memory as pretty good. He was managing his ADL's fairly well at that point, and there were no glaring issues.

c. Cognitive skills for daily decision-making: On this scale for assessment, there are points, and the total points achieved places the individual along the continuum. There are 5 different points, so moderate is in the middle. A computer adds the score. Ms. Dykslag found Mr. Salter's skills in this area moderately impaired.

d. The report also considered indicators of delirium. Ms. Dykslag discussed Mr. Salter's agitation and disorientation in this category. She stated there were indicators, such as getting lost and saying things like he didn't know where he was, that indicated Mr. Salter's safety was endangered. She felt the level of disorientation was "a problem".

[97] The second MDS-HC Assessment completed by Ms. Dykslag on December 4, 2007 was done so soon after the first because the first served as her baseline, and she needed to see what changes had occurred in Mr. Salter's condition. The second assessment was done with input from Ms. Jones and Dr. Ikuta, after both had seen Mr. Salter.

[98] Colleen Jones, R.N., B.N. is a geriatric consultant with Alberta Health Services Home Care in Lethbridge. Her extensive background in nursing, especially in geriatrics, acute rehabilitation and cognitive assessments, are set forth in her C.V., Ex. F6.

[99] Ms. Jones was aware of Mr. Salter's wandering and after discussing the situation with him, stated, "he doesn't want to wander outside at night again". The wandering seemed to have subsided because of the night care.

[100] In her interview with Mr. Salter, Ms. Jones found him gruff at times, but co-operative. She thought he gave her answers that she wanted to hear. He appeared lonely. She noted Mr. Salter's shortness of breath when walking or talking.

[101] In Ms. Jones' opinion, some of Mr. Salter's behaviours, for example missing meals and excessive sleep, could indicate depression as well as dementia. One of Ms. Jones' assistants was a social worker completing her practicum for a master's degree by following selected patients, most of whom had depression and anxiety. Ms. Jones requested that Mr. Salter be followed by the assistant, but he was not interested.

[102] Initially, Ms. Jones did not consider placement a priority. The report she co-authored recommended further investigation.

[103] Together with Dr. Li, another member of the Community Transition Team, Ms. Jones prepared an assessment report dictated Nov. 6 and 7, 2007. The relevant portions of the report are as follows:

> **REASONS FOR REFERRAL**: Nocturnal wandering, decreased memory, query depression, and shortness of breath on exertion.
>
> **CURRENT MEDICAL/FUNCTIONAL PROBLEMS**: Sydney Salter was seen at his room in The View with collateral information obtained from his son, Michael, via telephone and e-mail. Mr. Salter's wife passed away on March 16, 2007. His son assisted him with selling their house and Mr. Salter moved into The View on approximately March 30, 2007. He stated that The View was selected by his son, although Michael told me that his dad had previously looked into moving there. Recently, Mr. Salter has

wandered outside during the night on two or three occasions and had to be let back into the building. He has no recollection of the details of those incidents and actually only remembers being outside on one occasion. It is presumed that the security guard saw him outside and assisted him back in. He appears to have memory problems and query depression. He has been missing meals at The View, sleeping a lot, and not doing his laundry. He is also short of breath on exertion. He is under no regular medical care and has recently transferred care to Dr. Dong, whom he has apparently only seen on one occasion in the remote past.

PREMORBID LEVEL OF FUNCTIONING: Mr. Salter was a recent referral to Home Care. Coordinator is Joy Dykslag. His son has arranged two hours of private care through We Care every evening. Workers initially stayed overnight for two nights after the wandering episodes. Now they come after supper to tidy up, do laundry, and ensure that Mr. Salter is settled for the night. Mr. Salter told me that they have been assisting him to shower. He was previously independent with ADLS. When questioned about his previous IADL status, Mr. Salter replied "It got done, I can't remember"….

COGNITION/PSYCHOLOGICAL STATUS: Mr. Salter's hygiene appeared adequate and he was appropriately dressed. His manner was somewhat gruff at times, but he was cooperative with the assessment, although it appeared at times that he may have been "covering". He appeared lonely. SIGECAPS [S: Sleep; I: Interest; G: Guilt; E: Energy; C: Concentration; A: Appetite; P: Psychomotor Changes; S: Suicide]: Mr. Salter stated that he is sleeping well, but his son reported that he has been sleeping "a lot". He has attended a few activities at The View, but seems to spend most of the day in his room. He has lost interest in playing cribbage and whist, which he previously enjoyed. When questioned about guilt, Mr. Salter replied "doesn't everybody?", then stated "No more than anyone else". He reported his energy as "pretty good". He denied difficulty concentrating and had no difficulty with either the serial 7's or spelling "world" backwards on MMSE [Mini-Mental State Examination]. He stated that he eats well, but apparently he has been missing some meals. There were some delays on the vigilance A's on the MOCA, but no other delays or agitation were noted. Mr. Salter denies suicidal ideation, but stated that this would be a good age to die. On Geriatric Depression Scale, Mr. Salter had five flagged responses out of fourteen. He was unable to answer either yes or no for the question "Do you think that most people are better off than you are?" His response was "some are, some aren't." Other flagged responses were for dropped activities and interests; feeling that his life is empty; boredom; fear of something bad happening to him; and preference to stay home, rather than going out and doing something new. Comments made throughout the visit included "I don't know why we ever came to Canada", "I am Eileen's husband", "I feel lost, is that normal?", "Sometimes I talk to her at night because I don't know what else to do", and "I'm just here until the day I pass on". On MMSE he scored 28/30, losing two points for delayed recall, with perseveration to the word "world" for one of his responses. For his sentence, he wrote "Will you believe me if I tell a lie?" On the clock, he had some difficulty with placement of numbers. Hand placement was appropriate for the time 11:10. On the MOCA, his score was 18/30. He lost points for alternating trailmaking: copying a cub;

reversal of the hands on the clock; calling a rhinoceros a hippo; one point for vigilance A's; one point for fluency, only naming eight words beginning with the letter "F" in one minute; one point for abstraction; and five points for delayed recall. He recently forgot that his Home Care Coordinator was coming to visit him, although she had prearranged the visit with him. He was unable to tell her when he moved to The View or provide details of his health history. Today, he did not seem to be aware that there is a call bell system in his apartment. He reported that he changes his bed linens, although a staff member came in to do so while I was there. He was sketchy with details of his wife's illness, his own health history, and his premorbid IADL status. He was unable to describe similarities for two out of three examples and on proverb interpretation, he gave semiabstract responses for two examples and was unable to interpret the third one at all. Judgement and insight appeared to be fair. According to Michael, Mr. Salter has been concerned about having Alzheimer's because he has a lapse of memory of some events around the time of his hip surgery. He has repetitively told Michael that he is convinced he has had "blackout periods". There is no previous psychiatric history. Mr. Salter was a previous smoker, but quit in mid-forties. He has never been much of a drinker, but enjoyed an occasional Scotch.

CURRENT ADLS/IADLS: Mr. Salter remains independent with all ADLS except showering. Food preparation, cleaning, and laundry of towels and bed linens are provided at The View and staff from We Care assist with tidying and do Mr. Salter's personal laundry. Mr. Salter's son did not report any concerns about his dad's ability to manage his finances and I noted a file folder with neatly filed bank statements on his coffee table at the time of this visit. Mr. Salter still goes out occasionally for banking or other errands, with transportation either by taxi or the shuttle from The View. He communicates with his son by phone, although I suspect that Michael initiates most of the calls.

RECOMMENDATIONS: Following consultation with Dr. Li, the following recommendations were faxed to Dr. Dong:

1. Consider doing dementia screening lab work, including CBC, diff, lytes, creatinine, urea, B12, Glucose, TSH, calcium, albumin, ESR, urinalysis & C & S, as well as ALT & Alk. Phos. if suspicion of liver disease.

2. Consider chest x-ray, PA and lateral.

3. Consider starting Citalopram 10 mg qd x 2 weeks, then 20 mg qd x 2 weeks, then 30 mg qd.

4. Book appointment with geriatrician. Mr. Salter is scheduled to see Dr. Ikuta in Outpatients at the Chinook Regional Hospital on Monday, November 26, 2007 at 10:00 a.m.

Mr. Salter's son was notified regarding the above recommendations, but is unable to attend the appointment with Dr. Ikuta with his father. Mr. Salter's Home Care Coordinator has been involved in coordinating the above recommendations and transportation to appointments.

[104] Throughout the assessment process, Ms. Dykslag was in communication with Mr. Salter's son. For example, on November 23, 2007, she sent him an E-mail which she described as an "update":

> I just wanted to drop you a note to update you on your Dad. He made it to his Dr's appointment on Monday. The chest x-ray & blood work were all done. Dr. Dong also started him on the anti-depressant Celexa. I checked today, & the med is in a blister pak & he appears to be taking it appropriately. There is a note next to the blister pak saying – Take one each day after breakfast. He was a little confused today when I visited. He was by the front door when I arrived, as I stopped to speak with Judy & Tom for a few minutes before I saw him. Judy said to him – "I thought you were going to get your coat?" He said "I don't know where I am. I've sold my house…" I confirmed with him that yes he had & he lived her [sic] now & his room was just over there. I told him we would go back to his room. We walked back & he seemed to know where he was going. He was attempting to find a jacket & came up with a sports jacket that was too small. I told him he needs his winter coat as it is cold out. He really did not know where to find it. I found some jackets in his front closet. I tried to talk him into staying home but he was pretty set on going. So I walked him out – he did not even know where they were going. I stopped at the office to ask, the bus driver came, Tom assured me that he would be okay with the bus driver, & off they went.
>
> Management at The View are concerned about your Dad especially now that the weather has turned cold. They are concerned about him wandering out at night. I certainly hope that if he does open up his outside door at night, that the cold air will blast him & he'll just shut the door & not wander out. He is to see the Geriatrician (Dr. Ikuta) on Monday, & once we have his perspective, we will look at where the best place for him to live will be.
>
> …
>
> At this time I am unsure where you [sic] Dad will end up. It will be either Enhanced or DAL. I'm hoping Enhanced, but it will dependon [sic] his wandering. If we are really lucky, we may be able to manage him at Lodge level if there is something the Geriatrician can do for him.

[105] Michael Salter's response agreed that they would have to wait and see what Dr. Ikuta said. He also included the comment, "I've tried to call Dad every day or two, and he certainly seems with it."

[106] Both Ms. Dykslag and Ms. Jones were of the view that Mr. Salter needed to see a geriatrician. As indicated by Ms. Jone's report, an appointment was booked with Dr. Ikuta on November 26, 2007.

[107] Dr. Roland Masato Ikuta is a geriatrician who commenced his practice in Lethbridge in 1998. He describes the primary focus of geriatric medicine as dealing with diseases that predominantly affect the elderly. Diagnosing dementia and treating people with cognitive disorders are a large part of his practice.

[108] Dr. Ikuta's understanding was that Mr. Salter was referred to him because there were concerns about Mr. Salter's cognitive functioning and nocturnal wanderings. He was advised of two situations where Mr. Salter had left his room and was unable to retrace his steps.

[109] When doing an assessment such as this, Dr. Ikuta's nurse, in this case Colleen Jones, typically gathers information first. The nurse would obtain information from the patient, the family, caregivers, the pharmacy, and homecare. At the time of the appointment, the nurse first sees the patient. She conducts some memory tests and checks vital signs. Dr. Ikuta would then spend approximately one to one and a half hours examining the patient. Typically this would occur at the Chinook Regional Hospital where the patient would be seen as an out-patient.

[110] This process was followed in the case of Mr. Salter. Ms. Jones spoke with Mr. Salter's son in order to obtain his psychosocial history, which included information on Mr. Salter's educational background, habits such as smoking, and his current living and legal situations. As a result, Dr. Ikuta was aware that Mr. Salter had moved to the View shortly after his wife passed away, and that his only son lived in Arizona. He knew that We Care was providing assistance to Mr. Salter. Dr. Ikuta described the patient's "current legal situation" as knowing whether an Enduring Power of Attorney or Personal Directive were in place. He considered this important information because if he concluded that the patient could not make sound decisions anymore, he needed to know if there was a source to help with decisions. Dr. Ikuta understood that both documents existed but that neither had been enacted for Mr. Salter.

[111] Dr. Ikuta was aware that Ms. Jones had spoken with Dr. Li, who provided the opinion that Mr. Salter should see a geriatrician. He also knew that Mr. Salter was taking Celexa, and needed reminders to take it every evening. Celexa is an anti-depressant which is considered a good drug for treating depression in the elderly because it has few side effects. Dr. Ikuta was not aware of any information which suggested Celexa could contribute to forgetfulness.

[112] When Dr. Ikuta performs an assessment, he looks not only at dementia problems but also the overall physical health of the patient. For example, when Mr. Salter came into the room, Dr. Ikuta noticed he was short of breath. After examination, he thought Mr. Salter had a mild form of emphysema and restrictive lung disease, meaning his rib cage could not expand.

[113] Dr. Ikuta testified there are over 100 potential causes for dementia. The most common one is Alzheimer's, which he described as a degenerative disorder that is not completely understood. The prevailing opinion is that a person inherits a genetic tendency for Alzheimer's, and then there is an external triggering factor such as a stroke, coronary bypass surgery, meningitis, or one of many other triggers. Very specific protein abnormalities seem to be present in people with Alzheimer's, although it is not known whether these abnormalities cause the disease. The disease usually affects people in their seventies to eighties.

[114] The second most common cause of dementia is vascular, which is stroke-related dementia.

[115] Mr. Salter's muscular examination showed facial weakness on the left side, stiffness on the left side, and increased tone on the left side. This provided Dr. Ikuta with evidence of a previous stroke.

[116] Mr. Salter was given a Mini-Mental State Examination. This is simply a screening tool, but was indicative of problems. The cut-off score is 26 out of 30, and Mr. Salter scored 25 out of 30. Given his educational and vocational background, Dr. Ikuta expected him to do better.

[117] Dr. Ikuta concluded that Mr. Salter was suffering from mixed dementia, meaning there was more than one cause. There were two causes in Mr. Salter: an old stroke, and Alzheimer's. There was no confirmation of a previous stroke, so Dr. Ikuta recommended a CT scan to characterize where the stroke had taken place and how extensive it was. He did not believe Mr. Salter's cognitive difficulties were related to depression, so he recommended that the Celexa be discontinued and Mr. Salter start taking Reminyl.

[118] Reminyl is specifically used for dementia, and has been shown to be beneficial in people with both Alzheimer's and stroke-related dementia. It generally does not help people get better and recover lost memory, but prevents the memory from getting worse. 20% of the people who take Reminyl experience a noticeable improvement in their cognitive function, and 80% experience stabilization, meaning their memories don't get worse, but retain their current levels of functioning.

[119] Reminyl is a daily medication, but in Dr. Ikuta's opinion, if a person missed taking the drug a few days, nothing would really be noticed. It also took about four to six weeks, with six weeks being the average, for Reminyl to have an affect.

[120] The only other medication recommended by Dr. Ikuta was a daily coated Aspirin.

[121] Dr. Ikuta and Mr. Salter discussed the living arrangements at the View. Mr. Salter felt he was managing well there, but also indicated he had no attachments to it and was willing to move and consider a place where he could get more assistance. Dr. Ikuta thought Mr. Salter needed to move because the View was not sufficient to meet Mr. Salter's care needs. In his opinion, Mr. Salter required placement in a designated assisted living facility.

[122] Dr. Ikuta thought an assisted living facility would enable Mr. Salter to manage very well because it would prevent him from wandering, would give 24-hour supervision, and would assist him with his medication, meals and personal hygiene. However, he did not perceive Mr. Salter's need to move as urgent or immediate because he knew We Care was going in nightly and helping Mr. Salter settle for the evening.

[123] In summary, Dr. Ikuta recommended that Mr. Salter undergo a CT scan; discontinue the Celexa; start taking Reminyl and Aspirin; and move to a designated assisted living facility. He originally stated that he thought Mr. Salter's Enduring Power of Attorney and Personal Directive needed to be enacted, but then confirmed that he did not think they needed to be enacted yet. In Dr. Ikuta's opinion, Mr. Salter was still capable of making decisions.

[124] These recommendations were made based on the information obtained by Dr. Ikuta's nurse and the examination Dr. Ikuta conducted on November 26, 2007. The conclusion of Mr. Ikuta's report, prepared after Dr. Ikuta completed his interview with Mr. Salter, stated the following:

> **IMPRESSION AND RECOMMENDATIONS:**
>
> Mr. Salter is an 88-year-old gentleman who presents with cognitive deficits. His current findings are very much consistent with mixed dementia. I have requested a CT scan of his head. He does not have any depressive features and thus, I will contact Skelton's Pharmacy and ask them to discontinue his Celexa. In it's place I would recommend that he needs to go on Reminyl at an increasing dose. In terms of his current function, with assistance from We Care he is managing so I do not think there needs to be an urgent move. However, it is clear to me that this gentleman is needing more care than can be provided at The View. I will

> talk to his son and suggest that Home Care evaluate him for placement into a high level of care and I suspect he would likely come out as a DAL level. He certainly needs assistance with his personal hygiene, his meals and his medications…he needs supervision to make sure that he does not wander off at night. I am hopeful that the Reminyl will help stabilize his cognitive deterioration. At this point I do not feel that his EPOA and PD need to be enacted. I talked to Mr. Salter about a possible move and he certainly made it sound like he was more than willing to and that he is not particularly attached to The View. I do think he should also be on an Enteric Coated Aspirin once a day to prevent future strokes. Further investigations, other than the CAT scan, could include include a Holter monitor, carotid Doppler and echocardiogram. However, given his age I will not pursue these at this point unless his son feels strongly that he would like to.
>
> Mr. Salter likely has a mixed dementia and will commence on Reminyl and will need to be considered for a higher level of assistance.

[125] Dr. Ikuta only vaguely recalled corresponding with Mr. Salter's son about the results of his assessment and the availability of beds. The E-mail by Dr. Ikuta to Michael Salter on November 26, 2007, after he saw Mr. Salter, is therefore reproduced:

> Hi, My name is Dr. Roland Ikuta. I am the Geriatrician(specialist who looks after seniors) that saw you Dad today. I had a chance to see all the notes you sent to Colleen and also to talk to the lady from We Care. She certainly seems to have a good handle on what is happening to your Dad and seems very caring. In terms of his diagnosis he definitely has a dementia but it is fairly early. He was started on Celexa which is an antidepressant but I think there is no indication so I have asked the pharmacy to stop it. His dementia is likely secondary to a small stroke and probably a component of Alzheimers disease. In terms of his living situation I do not think things will last very long in the "View". It is a setting that is for independent seniors and not for those who have dementia and care needs. I think he would manage well in a setting called Assisted Living. I feel he should be evaluated by Home care ASAP and put on the wait list for one of these facilities. I think he can manage at the View in the interm [sic]as long as you can continue with the help from We Care. I would be a little concerned about getting one of the home care agencies to take over as he has gotten used to his current help and it will likely confuse him even more if there were a new set of ladies coming to assist him. I do not feel that his Power of Attorney and Personal Directive needs to be enacted yet. He was very cooperative and was very much willing to consider a move if it would help him. In terms of his current medical situation I do believe he has had a stroke affecting his left side which may have caused his mental deterioration. I have requested a CAT scan of his brain which will be done some time in the next 4-6 weeks. There is no urgency for this scan. I do not know what your situation is but is there any thought to him coming down to be looked after by family? If not he will need to go into care fairly soon. I think it would be important to start the process soon. I did start him on a new medication called Reminyl (Galantamine) which may slow down the deterioration seen in dementia. He also has mild emphysema and a very restricted chest which is causing some of his shortness of breath. Not much else to suggest at this point. If you have any question [sic] please

> do not hesitate to contact me. It may be best to try to get ahold [sic] of me by this email address

[126] In a reply E-mail produced from the records of Ms. Dykslag, who was copied on Dr. Ikuta's E-mail, Michael Salter thanked Dr. Ikuta for the quick response and stated that he was not surprised by the diagnosis. He asked some questions regarding a medical issue not related to dementia and then asked, "if the scan does confirm a mild stroke, what are the implications of same and are there any therapies that would be indicated?" Dr. Ikuta was not specifically questioned on receipt of this E-mail and whether he responded to it.

[127] In his role as a geriatrician, Dr. Ikuta stated he is often dealing with situations of risk in the community. If the patient is competent, how much risk they are willing to accept is up to the patient, but typically there would also be consultation with the family to determine how risk adverse the patients are. He stated there are many situations where people live at a certain level of risk, and both they and their family are willing to accept it.

[128] After the completion of such a report, it was Dr. Ikuta's expectation that a copy of his report would go to Home Care, and typically Home Care and the family would start the process of an assessment, which was conducted by Home Care. The purpose was to evaluate what Mr. Salter's level of care should be and present the information to the Living Options Committee, which has the responsibility to make a decision on the level of care. Then the family is contacted and given selections of different facilities at the level of care suggested.

[129] As previously indicated, Ms. Dykslag completed a second MDS-HC Assessment on December 4, 2007, which included input from the assessments done by Ms. Jones and Dr. Ikuta. Ms. Dykslag found that Mr. Salter's cognitive patterns had not changed since her first assessment on November 16, 2007.

[130] Ms. Dykslag was asked when she reached the conclusion that a placement needed to be made. She stated that from the first time she assessed Mr. Salter, she felt that a placement really needed to be considered, and then after hearing from Ms. Jones and Dr. Ikuta, she thought it necessary, but she could not name an exact date. She stated that she presented Mr. Salter's case to the Living Options Committee on December 6, 2007, and needed all the paperwork to be completed by that date. The implication from this testimony was that she reached the conclusion that a placement was necessary prior to December 6, 2007.

[131] In order to have the complete medical record to place before the Living Options Committee, one of the requests Ms. Dykslag made was to Mr. Salter's family physician, Dr. Dong, to complete a Medical Assessment for Long Term Care. The request was made on November 30, 2007. Dr. Dong had seen Mr. Salter at the Campbell Clinic on November 19, 2007.

[132] Dr. Dong's completed form contained the following relevant information:

- Patient has had increased confusion and forgetfulness over the past year.
- Medication – celexa
- Rehabilitation Services; Physiotherapy; Occupation Therapy
- Diagnosis (in order of significant)
    1. dementia
    2. depression
- Diagnosis known by? Patient and family
- Prognosis: maintenance

- Reasons for recommending Long Term Care Placement: Patient unable to look after himself.
- [patient is aware of application and can be referred for a consultation for appropriate placement].

[133] The form appears not to have been faxed to Ms. Dykslag until December 11, 2007.

[134] At the Living Options Committee meeting on December 6, 2007, Ms. Dykslag, a manager from the access centre, a staff member of the access centre, and likely a senior coordinator from the community care office and a social worker were present. Ms. Dykslag stated the client and the family are not invited to be present, but are advised of what occurs. At the meeting, it was decided that enhanced care would be the appropriate living option for Mr. Salter. [NB: Dr. Ikuta did not recommend enhanced, but DAL care.]

[135] Golden Acres Lodge and Columbia Assisted Living were the two facilities that offered enhanced care services in Lethbridge in December of 2007. Despite the name, Columbia offered two forms of care: designated assisted living and enhanced care. Columbia Assisted Living was chosen as the preferred facility at the Living Options Meeting.

[136] Also on December 6, 2007, Ms. Dykslag sent one fax to We Care requesting that they assist Mr. Salter in taking his daily Reminyl dosage when it arrived from the pharmacy, and a second authorizing additional morning care for Mr. Salter. The fax to We Care requested that the same caregivers be used, as consistency of caregivers was important for Mr. Salter. Ms. Dykslag advised Michael Salter in an E-mail the following day that this was to be paid for by Chinook Health, not the family. The extra care was temporary.

[137] Ms. Dykslag also completed a five page "Referral, Admission to Enhanced Lodge" form on December 6, 2007. It included reference to Mr. Salter's conditions, especially wandering. Mr. Salter signed the form to authorize release of medical information to the lodge "for the purpose of determining eligibility for admission to an 'enhanced lodge' facility". The space for "Preferred Lodge" was blank.

[138] On December 7, 2007, Ms. Dykslag sent Michael Salter an E-mail providing an update on his father. Many things were discussed. The E-mail contained the following information on the enhanced lodges available to Mr. Salter:

> Now for his placement – There are 2 Enhanced Care Lodges in Lethbridge. They are Golden Acres Lodge on the north side & Columbia Assisted Living (don't let the name fool you, it is regular & Enhanced lodge level) on the West side. I believe there are rooms available at both places but that can change daily. Golden Acres is managed by Green Acres Foundation & the monthly rate is approx $1200 - $1300/month. It is a very old lodge & the rooms can be quite small. Columbia, on the other hand, is much newer & brighter. It is a privately owned facility, so the rates are much higher. Now, just to clarify, there are actually no Enhanced beds at Columbia right now, but they would take your father into a regular Lodge bed, offer him Enhanced care services at regular lodge rates until he comes up on the Enhanced care list. At that time, his rate will drop. Chinook Health subsidizes Enhanced & Assisted Living levels. Regular Lodge rates are $1655. for a studio & $1983. for a 1 bedroom (no 1 bedroom units avail). Enhanced rates are $1300 for a studio & $1850. for a 1 bedroom. There are extra charges of $50. for Medication Administration Program, $20 for cable, & $35. for laundry.

> There are also enhanced Lodges in Coaldale, Taber, Picture Butte, Cardston, Crowsnest Pass, & Fort Macleod. If any of these interest you, I can give you info on them.
>
> I feel that Columbia would be a better choice for your Dad just because it is a mix of regular lodge level people, as well as Enhanced level people. Other than your Dad's confusion, he is actually in pretty good shape & I think that Columbia is a little more active with less confused people for him to be around. The rooms are quite a bit nicer & definitely larger. It would actually be very nice if you could come here to see & tour these places with your Dad so you can make an informed decision, although, I know you're busy & it's difficult to get here. The only other thing would be if the We Care girl could take him for a look, but I'm not sure your Dad will be able to make this decision without you. What are your ideas about this? We kind of need some choices so he can be waitlisted.

[139] As discussed in the E-mail, Columbia Assisted Living would permit a person requiring enhanced care to move in even though there were no enhanced care beds available at the time. Ms. Dykslag testified the person would then receive 24 hour care, but would not receive the government subsidy until an enhanced care bed was available.

[140] Michael Salter indicated that he agreed with having his father move into the Columbia facility, however, he wished for his father to have a one-bedroom room instead of a studio room.

[141] According to Ms. Dykslag, around December 10th and 11th, the decision was made that Mr. Salter would be moving to Columbia. Since he was not at the top of the enhanced care list, he was offered a regular bed with a studio room, but the family wanted a one-bedroom room. Michael Salter wanted to wait for a one-bedroom room, but also felt that if his father came to the top of the enhanced care waiting list, he should take whatever room he was offered.

[142] Ms. Dykslag and the team thought Mr. Salter could stay at the View until the one-bedroom became available, however she also indicated this decision was the family's. Their other options would have been to take the studio room immediately, or not move at all until Mr. Salter's name came to the top of the enhanced care list.

[143] The team did not feel that Mr. Salter was at a level of incompetence where the government needed to step in and make decisions for him; Mr. Salter was still capable of making this decision.

[144] On December 10, 2007, someone noted on the "Referral, Admission to Enhanced Lodge" form that it was received and faxed to Columbia on December 10, 2007. The space for "Preferred Lodge" was now completed to show "Columbia E.L.".

[145] On December 11, 2007, Ms. Dykslag E-mailed the Access Centre:

> I left a message on the Access Center phone on the weekend & am just confirming that you got it. The first choice for Enhanced care for Sydney Salter is Columbia Assisted Living. His son Mike will speak with Marion and try to get him into a regular Lodge room to wait there until an Enhanced bed is available for him. I'll let you know what goes on.

[146] She received the following response:

> Joy – yes we did get the message. We have not processed the info as yet <u>because we are still short staffed</u>. Thanks for keeping us informed. [emphasis added]

[147] After seeing Mr. Salter on November 26, 2007, Dr. Ikuta's only other involvement with Mr. Salter concerned his medications and the CT scan. Dr. Ikuta was contacted and asked to phone the pharmacy to provide Mr. Salter's prescription for Reminyl, as it had not been received. Dr. Ikuta believes he gave the prescription to Mr. Salter, but it appears it was not filled. Dr. Ikuta contacted the pharmacy on December 12, 2007. Even if Mr. Salter then started taking Reminyl on December 12th, Dr. Ikuta does not believe it would have taken effect prior to Mr. Salter's death.

[148] Mr. Salter had the CT scan ordered by Dr. Ikuta on December 6, 2007. Although the typical wait time for a CT scan in the fall of 2007 was three to five weeks, Mr. Salter therefore underwent the scan in just over one week. The results were received by Dr. Ikuta's office on December 20, 2007. They confirmed the diagnosis of a small stroke. The scan also showed white matter disease, which means that small blood vessels in the area of the brain known as white matter have been occluded. In many cases this does not lead to any physical disability, but can lead to dementia or other problems, for example, imbalance.

[149] Dr. Ikuta could offer no explanation for why Mr. Salter got in for his CT scan so quickly. He did not feel there was any urgency for it to be completed, since the purpose of the scan was to identify the cause of the dementia in order to treat it down the road. There was nothing that could be done to treat it immediately. He was not concerned about the turnaround time from the date of the scan to the date of receipt of the results in his office, stating this was standard. Generally, the radiologist has to view the results and dictate a report, which is then transcribed. He stated that the turnaround time depends on the urgency of the request - if there was bleeding on the brain, for example, the radiologist would call immediately and not simply leave a report to be transcribed and sent.

[150] The CT scan report was sent to both Dr. Ikuta, as he requested the scan, and the family physician, Dr. Dong.

[151] Since there was nothing urgent in the CT scan report, Dr. Ikuta testified he would follow his standard practice, which is to discuss the results at the next follow up visit. He had requested a follow-up visit for Mr. Salter in six months. At this appointment, he would have discussed the results of the scan and how Mr. Salter was doing on the medication. He doubts that the actual appointment had been arranged prior to Mr. Salter's death.

[152] Ms. Dkyslag's last involvement with the Salter family prior to Christmas appears to have been on December 18th. Michael and Mr. Salter met with Ms. Dykslag and confirmed that Mr. Salter would wait at the View until an enhanced-care one bedroom suite became available at Columbia.

[153] Ms. Dykslag finished working on December 21st and was on vacation until January 2nd. No one at We Care contacted her in the last week prior to Mr. Salter's death, and no one within her organization briefed her that they had received any information that his health deteriorated while she was gone. In her absence, Ms. Dykslag has a partner who monitors her calls and deals with whatever issues come up. She felt that her partner would have charted anything that happened, and she was notified of no calls specific to Mr. Salter.

[154] On January 2nd, 2008, Ms. Dykslag received an E-mail from Michael Salter stating what had happened. After learning of the death, she thinks she called Michael, then notified the

access centre that there was no need for the bed. Mr. Salter's file was closed. Ms. Dykslag did not talk to the medical examiner.

[155] Ms. Dykslag was asked about many of her notes which refer to two night wandering incidents. She thought this information came from both Mr. Salter's son and the managers at the View. She also indicated it could have been from Mr. Salter. Both counsel conducting the Inquiry and Michael Salter indicated they were aware of only one night wandering incident.

Findings

1. Whether the decedent was living in the proper facility for his condition?

Response: No. The View was not a property facility in the circumstances.

[156] The evidence of all persons concerned with Mr. Salter's health care and accommodation essentially confirmed this statement by Mr. Goerzen made after he had spoken to the building management company:

> …"The View at Lethbridge" and building is an entirely independent living facility with residents being attended by home care per their own arrangements.

[157] The View "had no responsibility for overseeing or providing health care or personal services". Its staff provided services such as maintenance, housekeeping, transportation and meal preparation. Residents could, at their own expense, contract with outside agencies to provide nursing, caregiving and support services.

[158] By November of 2007 Alberta Health Services was assessing whether a placement was necessary for Mr. Salter, and in December of 2007, had approved and recommended he reside in a more secure facility.

2. Whether, with the benefit of hindsight, there were other alternatives available to the deceased that might have prevented this death, and which could prevent similar deaths from occurring in the future?

Response: This inquiry should not make an assessment based on hindsight.

[159] In *Melanson Estate v. Calgary Regional Authority,* 2008 CarswellAlta 1787 (Alta.Q.B.) Madame Justice Romaine cited the Supreme Court of Canada in *ter Neuzen v. Korn* [1995] 3 S.C.R. 674, [1995] 10 W.W.R. 1, 64 B.C.A.C. 241, where Sopinka J. cautioned and emphasized at para. 34 that where there are claims against doctors not to judge nor evaluate too harshly:

> …Courts should be careful not to rely upon the perfect vision afforded by hindsight…

[160] In this inquiry there is the risk that without independent expert evidence the assessment requested could result in health and caregiver professionals of reasonable ability to "be held accountable for mistakes that are apparent only after the fact".

[161] Further, an approach based on hindsight in a Fatality Inquiry may well be contrary to the Act which states:

> (3) The findings of the judge shall not contain any findings of legal responsibility or any conclusion of law.

[162] However, Michael Salter and Mr. Lewis, counsel for Alberta Hospital Services, made some comments that can be taken as recommendations.

[163] Mr. Salter stated that:

1. There must be better coordination of procedures and improvement in the communication process. Families need to be promptly and thoroughly informed. All of the care provider teams must work more closely together.

2. Although the CT scan was timely, issuing the radiological results was delayed.

[164] Mr. Lewis pointed out that:

1. There was a system, but people have to use it.
2. Once a decision is made, based on a judgment call, no one should speculate on security or the placement policy.

Recommendations for the Prevention of Similar Deaths

[165] *The [character] of a country can be seen simply in how it treats its old people.* [The Bratzlaver (1770-1811)]. From the evidence given at this Inquiry, the following points need to be recognized by clients, their families, and all people involved in private and public health care:

1. The challenges in health care are many and substantial, especially those bearing on persons suffering from Alzheimer's, dementia, and other cognitive abilities. The approaches to be taken and the best allocations of resources to meet the needs are difficult to match.

2. Rights must be protected and enforced. The protectors must be held accountable for their actions (or lack thereof).

3. It is necessary that existing procedures, protocols, and practices be constantly reviewed, assessed, revised, and tested to confirm that they are complete with sufficient details to provide guidance to all of the caregiver teams and especially to the patients and their families. The highest standards must be established and adhered to. This will require the utmost co-operation, co-ordination and expeditious communication from, to, and among all professional personnel, their associations, all concerned agencies, community groups, families, and persons with leadership responsibilities. Their decisions must be concurrent, and supported by meaningful, prompt, and remedial resources at and by all levels of government. Undoubtedly some suggested changes will not be acceptable to everyone. Debate will be animated.

4. Priority should be given to private, not shared, accommodation within secure facilities for nocturnal wanderers.

5. It is unlikely that one group or individual will know what is the best policy in each case. Patients, where possible, and certainly caregivers, but most likely advocacy groups will have a vital role in educating, planning and organizing proper health care. It will be a concerted, team based approach, that will take into account a region's needs and the required resources.

[166] It is my recommendation that an independent study which is conducted under the following standards and takes into account the following points be conducted:

1. An invitation be issued to all concerned stakeholders in each community to participate in the form of a grassroots response including, but not limited to:
   - federal, provincial, municipal authorities
   - health professionals
   - health care providers
   - operators of health care facilities, including independent living facilities
   - concerned associations and individuals

2. Within 30 days of receipt of this report, under the leadership and guidance of the Ministry of Health, all stakeholders should complete plans to arrange for a study group to meet within 60 days to complete and publish its findings and recommendations by January 31, 2010 at the latest.

3. All policies, protocols, assessments and procedures should be reviewed and assessed to determine and confirm all strengths and weaknesses in order to ensure the best urgent care and protection is available at appropriate levels for all persons with cognitive impairments.

   This outreach should include reference to current studies such as the Senate Special Committee on Aging and of the Royal Canadian Legion and communication with their experts.

4. Consider the question: what will best protect the client as advocated by the best and most experienced experts at all levels?

5. Conduct a review of current communication systems to ensure they provide maximum operational efficiency and expediency. These communication systems should also ensure that immediately, whenever and wherever any signs of deterioration or marked departure in health is noted, that an alert is communicated to all involved health care providers, as well as the concerned families. Any written confirmation procedures should be accompanied by an acknowledgement by each recipient.

6. Compare past and present conditions and projections for the future, anticipating community populations and the ratio of people with cognitive impairment requiring short and long term accommodation and caregiving for the following years or periods:

   2005
   2010
   2015
   2020

7. Identify the needs of “wanderers”, especially nocturnal ones, who require urgent “24/7” safe, secure facilities with qualified staff to provide care and protection by taking all relevant factors into consideration, including:

   (i) in addition to, or as replacement to locked/secure facilities, what personal

protective devices (e.g. personal sensors with GPS indicators) can be used to monitor and supervise wanderers? Should the emphasis be on electrical monitoring such as sensors on the arms-wrists, legs or elsewhere on the body? Should there be sensors to indicate the opening and closing of doors? Should sensors be combined with video surveillance?

(ii) just as soon a person wanders, should she or he be considered in need of urgent care to commence forthwith? If so, what plans and provisions must be in place?

(iii) once needs are confirmed, plans should be implemented or tested as soon as possible.

8. Confirm that there are and will be immediate and long range planning, adequate recommendations to ensure medical and nursing care, caregiving, protection and quality of life that ensures immediate responses to urgent needs.

9. Consideration should be given, if necessary, when it is in the best interests of the patient, that the Province enact/amend legislation to allow doctors to recommend terms that will promptly provide patients in need with secure/safe designated accommodation and care.

10, The final plan should be subject to continuous and rigorous peer review.

Exhibits

Exhibit #F1 Alberta Justice – Black Binder – Documents are from Medical Examiners Office, The View, and from Alberta Health Services. Green sticker dot on front with B001 written on it. Tabs are numbered 1-17**.** List of exhibits are listed on the first page in a plastic cover.

Exhibit #F2 Alberta Justice – Affidavit of Elvin and Wilma Strand, 6 pages, appears to be a photocopy, first page indicates in the top right hand corner: date affidavit sworn: May 7, 2009, last page is photocopies of drivers licences of Elvin and Wilma Strand.

Exhibit #F3 Alberta Justice – Lethbridge Regional Police Service Investigation File, 07027361, 13 pages, appears to be all photocopies documents.

Exhibit #F4 Chinook Heath Community Care – Chinook Health Community Care Record for Sydney James Salter, grey binder, front of binder has a green sheet of paper under plastic indicating Chinook Community Care – Sydney James Salter – Inquiry May 28, 29, 2009 Lethbridge, AB, also notes file: 3590-141/KHL.

Exhibit #F5 Alberta Justice – We Care Home Health Services records, 25 pages in total, appears to be all photocopies, stapled together, first page indicates at top right hand corner "printed by: Cyndy M."

Exhibit #F6 Alberta Justice – Curriculum vitae of Colleen Jones, 4 pages in total, first page indicates Colleen Jones, R.N., B.N., GNC(C) Geriatric Consultant, Community Transition Team, Alberta Health Services, Lethbridge

Exhibit #F7 Alberta Justice – missing part of a document from Exhibit #1 (page 52 and 52A), 2 pages appears to be photocopies, front page indicates community transition team referral form, second page appears to be client history – written notes (this is the page that is not included in the binder), bottom of pages indicate Page 1 of 2 and 2 of 2.

Exhibit #F8 Alberta Justice – Chinook Health Community Transition team documents, 7 pages, first page indicates Chinook Health, Psychogeriatric Consultant – social work case summary, pages are numbered in the top right hand corners #1-7.

Exhibit #F9 Alberta Justice, 1 page, Chinook Health Region Flow Chart, page indicates Chinook Health Region, 2007 Clinical Divisions, blue pen scribbled at top of the page.