ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts

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

on the 17th to 20th days of June, 2017 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before D'Arcy DePoe, a Provincial Court Judge,

into the death of Robert Earl WRIGHT (Name in Full) 84 (Age)

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

Date and Time of Death: August 24, 2015 at 02:15 hours

Place: University of Alberta Hospital, Edmonton, Alberta

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *Fatality Inquiries Act*, Section 1(d)).

Multiple injuries from motor vehicle / pedestrian accident

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

Accidental

Circumstances under which Death occurred:

Mr. Robert Earl Wright, aged 84 (date of birth March 14, 1931), was admitted to the Geriatric Unit of the Royal Alexandra Hospital (RAH) July 29, 2015. The primary issue he was contending with was dementia. He was admitted on a Form 1 warrant under section 7 of the *Mental Health Act*. He had eloped from the hospital on several occasions prior to the day he died. Mr. Wright was placed in what was said to be a secure unit. He was supposed to be under constant care; specifically, it was ordered by his physician that a nursing assistant be constantly present.(an order known as "NA Constant"). He was to be on the ward for an indefinite period, until a bed in a secure permanent facility could be arranged. The order of NA Constant was not consistently followed, and was changed by staff, in accordance with the practice at the time.

On the date he died, he eloped, that is, he wandered outside the hospital, and eventually into traffic where he was struck by a motor vehicle. He was seriously injured and passed away in hospital three days later.

The door through which he escaped was a rear fire door that was supposed to be alarmed, but it inexplicably malfunctioned.

The Procedure Related to Fatality Inquiries

This Fatality Inquiry is a public inquiry under Part 4 of the *Fatality Inquiries Act* of the Province of Alberta to hear evidence so as to make certain findings in respect of the death of Wright. The Attorney General did not direct that a jury be summoned. Accordingly, I held the Inquiry as a Provincial Court Judge sitting alone with all the powers of a Commissioner appointed under the *Public Inquiries Act*. It was not a trial. It was a factual inquiry. At the conclusion of the Inquiry, I am required to submit this written Report to the Attorney General.

The Report must contain my findings as to the following: the identity of the deceased, the date, time and place of death; the circumstances under which death occurred; the cause of death; and the manner of death.

My Report may also contain recommendations as to the prevention of similar deaths. However, I am not permitted to, nor will I, make any findings of legal responsibility (see Section 53(3)) or draw any conclusions of law (see Section 48(1)). What follows is a review of the Inquiry including the circumstances of the death of Wright, and my final decision on recommendations.

It is my understanding that the Government of Alberta, in receiving this report, may do one of the following:

1. Accept recommendations made and implement them; or
2. Accept recommendations made, but not implement them; or
3. Not accept any recommendations.

The Course of the Inquiry

The Fatality Inquiry heard evidence over the course of four days. Evidence was heard from June 17th to 20th, 2017. Six witnesses were called, and extensive exhibits were entered, the bulk of which were the medical records relating to Mr. Wright. The evidence was further augmented by materials and correspondence provided by counsel. I will review the relevant evidence before I address any recommendations.

The Witnesses

Kathryn E. Lechelt

The first witness called was Dr. Kathryn E. Lechelt. She is a physician and Associate Clinical Professor in the Department of Medicine at the University of Alberta. Her specialty is geriatric medicine. Her c*urriculum vitae* was entered as Exhibit 3. She is obviously well-qualified and has a wide range of experience. Mr. Wright was her patient.

Dr. Lechelt described that in 2015 there were limited beds in the Geriatric Unit at the Royal Alexandra Hospital (RAH). There were only 30, with 15 more shared with stroke patients. There would be beds available on other units. The Geriatric Unit was not a locked unit; the doors were left open during the day but anyone coming and going would pass by the nursing station near the entrance. Any patient admitted with dementia would not be permitted to leave the hospital.

Mr. Wright was admitted to this unit July 29, 2015 after he was brought to the emergency department. He was displaying increased aggression as well as paranoia towards his spouse. The patient had already been diagnosed with possible Alzheimer's dementia. He was almost immediately placed on a wait list for a secure treatment bed at a secure long-term care facility in Edmonton.

Dr. Lechelt described in considerable detail the course of care provided to Mr. Wright while at the hospital. Of particular note to the Inquiry, Mr. Wright eloped from the hospital on August 8, 2015. It is not known how long he was gone but he was found a couple of blocks away from the hospital near Victoria School. As a result Dr. Lechelt issued a "NA Constant" order. Again, this is an order for constant observation of the patient by a nursing assistant. This was duly noted on Mr. Wright's chart. According to Dr. Lechelt, such an Order is meant to be indefinite. It means to her that there will be constant shadowing of the patient, that is, there should be a nursing assistant present with him at all times, and they are not to let the patient out of their sight. Sometimes the nursing assistant would sit outside the room when the patient is sleeping. When she writes such an order it is expected it will be followed by staff.

Dr. Lechelt indicated that a secure unit would have resolved this issue and that ideally every hospital should have a secured unit.

On August 11, 2015 Mr. Wright again eloped from the unit at approximately 17:00 hrs. He was found walking downtown by Edmonton Police Service members, and was brought back to the unit by hospital security at approximately 21:00 hrs. It appeared that the NA constant order was not being followed.

The medical chart reveals that on August 12, 2015 at 16:20 hrs, the NA Constant order was renewed "in evenings". This meant to Dr. Lechelt from the period after supper to the time Mr. Wright went to sleep. Dr. Lechelt said that this was "for emphasis" due to the fact that such patients are more restless, more agitated and more redirection is required at night. He remained a high elopement risk.

On August 13 Mr. Wright tried to leave again. He was behaving aggressively and security had to be called. He was giving calming medication. On August 20, 2015 he wandered off the unit again and was found within the hospital one floor below. Dr. Lechelt concluded that his elopement risk remained high.

One problem that continually arose with males who suffered from dementia is that they are constantly dealing with female staff. Such patients do not always react well to female nurses. More male staff is required, especially for patients like this who have issues with physical aggression, according to Dr. Lechelt.

Finally, it was acknowledged by her that the NA Constant order could be ended by other staff. Dr. Lechelt was of the view that there should first be communication with the treating physician. She felt her order should have stood. Nowhere in the chart does it indicate that the NA Constant order was removed, however, on August 15 the chart was noted "Constant PRN", (PRN means "when necessary "from the Latin *pro re nata*), which appears to mean the NA Constant order was modified to "when necessary".

Alvin Injoles

Mr. Injoles was employed as a nursing assistant at the relevant time period. He described his general duties on the ward as running errands, taking vitals, testing blood sugars, taking blood samples and generally "helping those superior to me". He knew Mr. Wright and understood that he presented an elopement risk. He did not know why he was hospitalized.

The door at the rear of the ward through which Mr. Wright escaped required a code to be entered to be activated. It should have been locked at all times and when opened makes a beeping alarm sound audible throughout the unit.

Late in the evening of August 21 he observed Mr. Wright in the hallway. He asked if he was okay and brought him back to his room [Room 7] and asked him to go back to bed, since it was almost midnight. Mr. Injoles then went to another room to respond to a bed alarm. Approximately 15 minutes after seeing Mr. Wright, at 23:45 hrs, he was informed that Mr. Wright was missing and started to search the unit. Unable to find Mr. Wright, he went down to the main floor as well as the basement and the emergency room. Security was informed at 23:50 hrs that Mr. Wright was missing. When he went back to the unit, he found out that the back door, which was supposed to be a secure one, was open, and not armed. He pushed the door open and no alarm sounded. The alarm appeared to be nonfunctional.

(The Inquiry was informed that an immediate request was made to have it repaired and this was done the next day.)

Joskin Cleto

Mr. Cleto was a registered nurse on the Geriatric Unit. On the night Mr. Wright disappeared there were two registered nurses, two licensed practical nurses and one nursing assistant on duty. The effect of his evidence was that on occasions where there was an order for NA Constant one additional nursing assistant would be provided. On the night of Mr. Wright's elopement, they didn't get anyone. Mr. Cleto advised that situation has changed and now they always have an extra nursing assistant where there is a NA Constant order.

Mr. Cleto also indicated that since the since the incident new processes have been developed whereby the team meets at the beginning of every shift, and among other things, special patient instructions are discussed and recorded so that all staff are aware.

Mr. Cleto confirmed that the unit was not locked and there is a door/exit at the back accessible by means of a keypad. The door is normally locked and alarmed. He believes that on the night Mr. Wright eloped the door was not alarmed, or at least the alarm did not sound. No one on the unit seemed to be aware of when the door alarm had stopped working.

He confirmed that an NA Constant order meant that a nursing assistant was responsible for watching a single patient individually for the entirety of the shift. Such an order could be made by the unit manager or the charge nurse in liaison with the patient physician, but in his view it did not require an order from the physician. This was his understanding of the practice since he started in 2009. When asked if once an order is made it should carry on indefinitely, he said “it should be”. The final say belongs to the doctor or the unit manager. If such an order was to be changed it should be charted that no more NA Constant is required.

Mr. Cleto noted that on the patient chart for August 20 there is no indication that an NA Constant order was in place, but nowhere was it indicated that the order had been discontinued.

He saw Mr. Wright around 23:30 hrs on August 21. This was at the nursing station at the front counter area of the unit. Wright was redirected by other staff to his room. During that evening Mr. Wright was described as cooperative with no clinical concerns.

At 23:45 hrs he was advised that Mr. Wright was not on the unit. A search was conducted throughout the hospital by staff but Mr. Wright could not be found. Around midnight he was informed by security that the door at the back of the unit was open. They went down the stairway leading to the main floor and noticed that the door leading out of the hospital on the main floor was also open. Shortly after midnight he learned from the emergency room that Mr. Wright had been struck by a vehicle near the hospital.

Donalda Dyjur

At the time of the hearing Ms. Dyjur was the Executive Director of the Internal Medicine Program, the Emergency Program, and in charge of Clinical Operations at the Royal Alexandra Hospital. She testified about the geriatric unit and confirmed that in 2015 this was not a locked unit, but there were security measures in place. The rear door in particular was alarmed.

She detailed changes that have been made since the incident with Mr. Wright. At the time of the hearing it was expected that the necessary funds would be spent to turn this unit into a locked unit within four to six weeks. Without a secure unit, the only strategy to deal with patients like Mr. Wright would be to employ a ”NA Constant” order. She noted that in 2015 there was insufficient staff throughout the healthcare system but that by 2017 more staff was available. The former situation apparently made full staffing on this unit problematic.

Ms. Dyjur also noted that the treatment team on the unit had changed its processes .She noted in particular that daily “huddles” took place four times a day at shift change. Staff are very deliberate about which patients are at risk and who is watching which patient. A document was developed entitled “Team Care Initiative” which discussed, in a formal way, staffing levels, named staff on duty, and listed total patients, empty beds, expected admissions, overcapacity patients, and so on. Special patient instructions regarding individuals taking tests, going for procedures, appointments or other matters were now recorded. Patients to be discharged or on passes were recorded. Finally, patients who had been certified, considered high risk or restrained on the unit were listed.

Another document was developed entitled “Care Plan Strategies Decision Tree”. The purpose was to provide general guidance for the management of patients identified as high safety risks, including those who represented a risk of elopement, or simply wandering. A copy of this document is appended to this report. The NA Constant option is not provided for. No explanation for this was offered.

It was noted that patients suffering from dementia who are an elopement risk are much harder to transition to a secure treatment bed.

Finally, and importantly, Ms. Dyjur was questioned about the issuing of "NA Constant" orders. She indicated that such an order could be ended by the team, the unit manager, or charge nurse, through discussion and dialogue. I will have more to say about this when it comes to making recommendations.

Eleanor Risling

Ms. Risling is the Director of Transition Services, Continuing Care, for Alberta Health Services (AHS). She oversees access and flow of patients into Continuing Care facilities. Generally speaking, dementia patients like Mr. Wright are placed into long-term care, in supportive and secure environments. Potential long-term care recipients are assessed according to standardized assessment tools, which have been in use since 2009.

Mr. Wright's assessment was completed June 29, 2015 and on June 30, 2015 he was placed on a wait list. It was determined that Mr. Wright needed to be placed in a secure unit. Mr. Wright was placed in an acute care bed on the geriatric unit at RAH awaiting transition to long-term care.

Detailed evidence was given as to the process of assessing and transitioning patients, and the options available, and the many difficulties clients with dementia have with transition to such facilities, but it is sufficient for these purposes to indicate that waiting lists are seemingly very long – at the time of this hearing there were 680 clients waiting, with 234 in acute care. Most of these were in non-secure units. Reducing the waiting list simply requires the construction of more secure facilities, which is largely dependent on increased government funding. This is quite obviously a political issue which is beyond the scope of this Inquiry. However, clients can wait many months for placement, but the median wait time for individuals like Mr. Wright is 48 days.

Corinne Schalm

This witness is the Executive Director for continuing care for AHS. She described in detail the differences between long-term care, designated supportive living, which is a lower level of care in a more residential like setting, and home care. There are long waiting lists for continuing care in Alberta and the government has significantly increased funding for this purpose in recent years. There has been a substantial increase in availability of secure spaces, but it is impossible to eliminate wait lists entirely, as it is too expensive to run facilities with vacant beds - there would have to be constant significant vacancy at every site.

She indicated that new technology has been brought into use, including GPS devices, and other monitoring systems including an ankle bracelet known as "WanderGuard".

Recommendations for the prevention of similar deaths:

I would point out first that similar issues at this Inquiry were raised in a public inquiry into the death of Wayne Lannie Pratt, presided over by my brother Judge Michael Dinkel in Calgary. He produced a Report dated February 28, 2017 which in my respectful view ought to be reviewed in conjunction with this Report.

It is fundamentally clear here that had Mr. Wright been on a secure unit, (or at least one that had a functioning locked rear door) which prevented elopement, his unfortunate death would not have occurred.

It is also clear that the only other thing which may have prevented his elopement was the NA Constant order issued by Dr. Lechelt. Such an order essentially means that a member of the nursing staff is to be in the presence of the patient at all times, in other words an “eyes on” shadow.

It is apparent that there was a significant disconnect in the understanding of staff on the unit as to just what NA Constant meant. Dr. Lechelt spoke of her expectation that on initiation of this order by a physician, it should only be discontinued by a physician, and even if others could decide to discontinue if it was felt that the patient no longer required it, she should have been advised. The second order of NA Constant that was given August 12, 2015, however, was written differently as “NA Constant evenings”. Again, on August 15 the order was recorded as “NA Constant PRN”. PRN is a medical term meaning “as needed”. This is unsatisfactory. In my opinion “as needed” is far too vague a term to deal with the complex issues facing Mr. Wright which could lead to his sudden elopement. He at all times remained an elopement risk.
Late in the evening of August 20, 2015, Mr. Wright seemed to be behaving relatively normally. He did not seem agitated and according to the evidence of the nursing staff there were no clinical indications that a constant watching was required. However, he eloped within minutes of these observations.

Many changes have been made since August 2015. This particular unit at the Royal Alexandra Hospital has been turned into a secure locked unit. WanderGuard technology is now being utilized. There have been communication enhancements within the unit, which are more deliberate and structured, and which are better documented. The incident seems to have generated alot of reflection and efforts to enhance safety. It is highly unlikely that such an incident could happen again on this unit.

The larger issue of the provision of more secure spaces to reduce wait lists to a minimum is dependent on financial resources available, and it is really beyond the scope of this inquiry to provide any meaningful input on that subject. It would seem to me however that every acute care hospital in this province should have a secure unit in order to transition patients. Once a patient has been assessed as requiring a secure unit, if at all possible simple common sense would dictate he should get it.

It is apparent that there will be situations in the future where NA Constant orders will have to be utilized, particularly in non-secure facilities. In my view it is imperative in situations where a secure bed is not available, that decisions to issue NA Constant orders should be made at minimum in consultation with a patient’s physician, and should not be changed or discontinued without similar consultation. Rules to this effect ought to be implemented. This is the major recommendation I make arising out of this inquiry. Dr. Lechelt was of the view that her order should not have been changed without her knowledge. This death may not have occurred if there had been a clear line of authority to make this important decision, starting with the patient’s physician, and proper communication to and among staff. All such orders should be in writing, recorded on the patient chart, and reviewed with staff every shift change.

All of which is respectfully submitted.

DATED September 14, 2018,

at Edmonton, Alberta.

"D. DePoe"

D'Arcy DePoe
A Judge of the Provincial Court of Alberta