REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at the Provincial Court of Alberta

in the City (City, Town, etc.) of Calgary (Name of City, Town, etc.)

on the 9th day of September, 19 91 (and by adjournment

on the 23rd day of January, 19 92), before

S. M. Bensler, a Provincial Court Judge.

A jury ☐ was ☒ was not summoned and an Inquiry was held into the death of

Elsie Rose (Name in Full) 90 (Age)

of Brentwood Nursing Home, Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death June 12, 1991 1330 hours

Place Brentwood Nursing Home, Calgary, Alberta

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

Subarachnoid Hemorrhage due to Craniocerebral Trauma

Manner of Death (''manner of death'' means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable — The Fatality Inquiries Act, Section 1(g))

Accidental

REPORT TO AG 338 - PAGE 2

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

(See attached page)

No. of additional pages attached 1 ½

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

(See attached page)

No. of additional pages attached ½

DATED this 23rd day of January, 1992.

A Judge of the Provincial Court of Alberta

S. M. BENSLER

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

Mrs. Rose, the deceased, was residing in the Brentwood Nursing Home on June 12th ,1991. She was 90 years of age and confined to a wheel chair.

On June 11th ,1991 , Betty Lou Beal , a personal care aide at Brentwood , was in charge of bathing Mrs. Rose. Ms. Beal and Lisa Brown lifted Mrs. Rose on to the century tub chair lift, a new device at the Nursing home to assist in bathing disabled people. Ms. Beal put the lap belt on Mrs. Rose. At that point Lisa Brown left and Betty Lou Beal continued to bath Mrs. Rose. Betty Lou Beal had fastened the lap belt of the chair loosely around Mrs. Rose and proceeded to hoist her into the bath. The shoulder belt which was on the chair was not used , although in Mrs. Roses condition it should have been. It was the first time Ms. Beal had used the century tub chair although she was said to have taken instruction on the proper procedures in the use and operation of the chair some months prior.

Bathing was carried out as usual. Ms. Beal then went to take Mrs. Rose from the Bath. She did not check the belt to see if it was still fastened and proceeded to hoist Mrs. Rose out of the tub. The chair was raised to the top position , about 46" above the floor to swing the legs over the tub and left in the top position facing away from the tub. Ms. Beal turned her back away from Mrs. Rose to move the wheelchair out of the way before lowering the chair. Ms. Beal then heard Mrs. Rose say "I'm falling , I'm falling ". Ms. Beal did not respond because she did not believe her. She looked around shortly after and saw Mrs. Rose lying on the floor on her left side. The lap belt was undone. It was indicated that there was no way Mrs. Rose could have undone the belt herself.

Mrs. Rose was taken to the Foothills Hospital by ambulance and seen by Emergency Physicians. She was treated for a laceration to the left temple and a laceration to the left forearm. An xray was taken of her left wrist. She was then sent back to the nursing home to be cared for . The only instructions given were that the stitches were to be taken out in 7 days.

Mrs. Rose was then sent back to the Nursing Home . She was attended to by the Nursing Staff until she died. They were to take her vitals every 30 min. and watch her through the night. Mrs. Rose was agitated and in some pain when she arrived back at the Home so Dr. Frazer, who was on call that evening, was notified . Dr. Frazer prescribed Gravol for Mrs. Rose to relieve nausea and vomiting. She was less responsive in the morning and her blood pressure was slowly dropping. Dr. Frazer was notified and came in to see Mrs. Rose. He prescribed morphine and advised the staff that they were not to revive her but to keep her as comfortable as possible in keeping with her age, her condition and the NO CODE order on her charts. Mrs. Rose died at 12:15 on June 12th 1991.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

To provide comprehensive training in the use of new apparatus in the Nursing Home. Training should include extensive practical experience to ensure Staff can operate these new devices before residents are exposed to their use. It is recommended that any Staff member who is to use the new apparatus or devices , demonstrate to the satisfaction of the Nurse or Nurses in charge of training that they are capable of the use and operation of such apparatus before they are allowed to operate them.