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 Provincial Court of Alberta

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

on the twenty-third day of June, 2009 (year), (and by adjournment

on the twenty-fourth day of June, 2009, (and by adjournment)

on the twenty-fifth day of June, 2009

before Judge William J. Cummings, a Provincial Court Judge,

into the death of Donald Edwin CLARK (Name in Full) 83 (Age)

of 6 Blockthorn Place N.E., Calgary, Alberta T2K 4Y3 (Residence) and the following findings were made:

Date and Time of Death: 7:51 p.m., July 5, 2007

Place: Intensive Care Unit, Rockyview General Hospital, 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)).

Hanging

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

Suicidal

Summary
Mr. Donald Edwin Clark was an 83 year old psychiatric inpatient in the Rockyview General Hospital in Calgary (the "Rockyview"). Mr. Clark had a past medical history of significant bipolar disorder, suicidal ideation and remote ethanol abuse.

He came to the Rockyview as an emergency patient, was referred for assessment and then admitted as an involuntary formal patient to Unit 48 on June 21, 2007.

On July 5, 2007, he was found in his assigned room hanging from a closet door with a belt tied around his neck and a hospital chair at his feet. He was resuscitated in the intensive care unit but his condition deteriorated and he later died.

Circumstances under which Death occurred:
Please see attached Circumstances-

Recommendations for the prevention of similar deaths:

Please see attached Recommendations-

DATED November 18th, 2009 ,

at Calgary , Alberta.

Judge William J. Cummings
A Judge of the Provincial Court of Alberta

Circumstances under which Death occurred

[1] Mr. Clark had a lengthy psychiatric history dating back to 1965 with a number of hospital admissions and a history of erratic moods and impulsive behaviour and was prone to depression and paranoid thoughts. His history of erratic moods and potential danger to self or others was of continual concern. There was a history of unstable relations between he and his wife prior to his last admission to the Centennial Center for Mental Health, formerly the Alberta Hospital, Ponoka (the "Alberta Hospital") in March of 2006. He was discharged in May of 2007 and moved to Calgary to take up residence with his daughter, Ms. Donna Cousins ("Ms. Cousins") for a period of six weeks until his eventual admission to Unit 48 at the Rockyview.

[2] On his last admission to the Alberta Hospital, Mr. Clark was referred on a Mental Health Certificate by his family doctor, Dr. Halls, who was not certain of his mental state. There were guns at Mr. Clark's home, one had gone missing and a safety concern arose. Mr. Clark was brought in to the Alberta Hospital by RCMP.

[3] Mr. Clark was angry that he had been admitted to the Alberta Hospital on this last occasion but volunteered to stay as an informal patient negating the criteria for Certification. The plan was to undertake an assessment, adjust his medication, stabilize his depression and see him discharged into another facility.

[4] Mr. Clark remained an informal, voluntary patient throughout the entire time of his last stay at the Alberta Hospital.

[5] During the week prior to his admission, Mr. Clark had sold his house in Ponoka and wanted to explore options for placement in Calgary knowing his wife had relocated and his family continued to reside there.

[6] Mr. Clark relapsed into a depressive state and responded only partially to medications. He became preoccupied with his inability to find a suitable placement in Calgary and to being alone in Ponoka with his wife and family in Calgary. These factors all compounded his depression.

[7] Dr. Vilas Kumar, a psychiatrist practicing at the Alberta Hospital working in the seniors' mental health program took Mr. Clark under his care during the entirety of his last 14 month stay at the Alberta Hospital. Dr. Kumar gave evidence in that capacity.

[8] Mr. Clark underwent several medication changes over the 14 months, responding only to some. He experienced depression and was irritable, angry and argumentative and resistant to and at times, non-compliant with his medications. Dr. Kumar testified he felt he had good rapport with Mr. Clark and was generally able to communicate with him concerning medications. Mr. Clark was compliant with his medications at the point of his discharge from the Alberta Hospital.

[9] During his stay at the Alberta Hospital, Dr. Kumar and his staff saw no need to put Mr. Clark on continual close observations and saw little risk of anything happening, even with his known preoccupations. Dr. Kumar recalls two instances where Mr. Clarke was depressed and was suicidal with a passive death wish. When pressed about feelings of suicide, Mr. Clark would respond by saying that he was "too chicken" to do anything. There appeared to be no intent or plan for him to harm himself. Over his 14 month stay, there were only two short instances where he needed close observation, one in July of 2006 when he expressed some suicidal ideation.

[10] As his stay progressed, there were points where Dr. Kumar felt Mr. Clark did not require acute in-patient care at all, even though he suffered from low-grade depression.

[11] Dr. Kumar knew Mr. Clark suffered from his mental illness for more than 40 years. Even knowing his history, it was still Dr. Kumar's opinion that Mr. Clark would likely be able to cope on discharge and that he was not then in any imminent danger to himself or anyone else. His depression had stabilized as had his medication and Dr. Kumar was not concerned about him being a suicide risk prior to his discharge.

[12] Dr. Kumar did not anticipate Mr. Clark's stay at the hospital to be more than six months but recognized the wait list for placement for people outside Alberta Hospital could stretch for months, sometimes years pending response from agencies in Calgary dealing with relocation. The hospital would not have discharged him had he not had a place to go. Had that been the case, the possibility still existed that he might have to pay rent.

[13] Dr. Kumar testified it is not always possible to predict the course of depression and bipolar disorder. In the dangerous periods, a patient's history and response to past medications is vital. In Mr. Clark's case, he was depressed but there was no history of him being actively suicidal in any of his four admissions to Alberta Hospital. Dr. Kumar saw that to be a good indicator of him not being at risk.

[14] Mr. Clark's placement in Calgary was explored. Ms. Cousins was renting a place in Calgary, had a room for him, and had access to a family doctor for follow up. The hospital agreed to the arrangement.

[15] Mr. Clark became increasingly anxious about moving as his discharge date approached. He told Dr. Kumar on several occasions that any time he did something, bad things go with him. Dr. Kumar assured him that if he was having these apprehensions, he did not have to go and could delay it until he felt confident in taking the step. Mr. Clark still chose to take up residence with Ms. Cousins.

[16] The objective on discharge was for Mr. Clark to eventually be placed at the Sunnyhill facility. The stay with his family was considered only an interim arrangement.

[17] Dr. Halls ceased being Mr. Clark's family doctor once he became an in-patient of the Alberta Hospital and a staff doctor took over that role during his stay. Mr. Clark's former family doctor would not be involved in coordinating his move to Calgary or liaising with a family physician there. Alberta Hospital has no outpatient services and relied on family physicians on discharge. Once the patient left the hospital, it was up to the family and the family's physician to ensure placement. The hospital had outreach nurses in the former David Thompson Health Region but could not follow a patient beyond the boundaries of that Region, a situation Mr. Clark faced by moving to Calgary.

[18] In Dr. Kumar's view, placement was far more difficult to arrange outside the former David Thompson Health Region and thus Mr. Clark's intended move to Calgary would be impacted. Patients looking for placement within that region would typically be placed earlier than if they were looking for placement somewhere else in the Province.

[19] Ms. Cousins gave the Court good insight in her father's circumstances and his personal life, particularly as it related to the time frame after his last discharge from the Alberta Hospital. Ms. Cousins and her sisters were greatly involved with and very concerned about their father's welfare throughout this last phase of his life. Ms. Cousins testified she spent three to four years navigating her father's problems through the system and found it impossible to find resources that would assist her.

[20] Ms. Cousins made significant efforts trying to relocate her father from the Alberta Hospital. She made inquiries to determine if Mr. Clark could be placed at the Colonel Belcher in Calgary but without

success. She also determined there were substantial lead times to move a senior in Mr. Clark's position into the Calgary Health region.

[21] Mr. Clark's daughters continued to look for placements for him on their own and were at odds with Dr. Kumar's decision to allow Mr. Clark to leave the Alberta Hospital. Ms. Cousins felt his behaviour did not warrant that. Her father had expressed a desire to get even with his family doctor for putting him back into the Alberta Hospital and had guns around his home in Ponoka. From her perspective, Dr. Kumar did not seem concerned and continued to suggest that Mr. Clark should have his freedom.

[22] At the point Mr. Clark was seen to be suitable for release into another facility, Ms. Cousins felt pushed to find another place for Mr. Clark to live.

[23] After taking up residence with Ms. Cousins following his discharge from the Alberta Hospital in May of 2007, there was still potential for him to be placed in the Sunnyhill facility but there was no indication when that might be. Mr. Clark appeared to know he was in trouble and would suggest going back to Alberta Hospital to obtain shock treatment which he had previously refused.

[24] Ms. Cousins saw Mr. Clark's condition deteriorate and his circumstances to become more pressing. She thought it might take another three to six months to find Mr. Clark another placement. Calgary Mental Health suggested she take her father to an emergency department to see if they could assist. Mr. Clark resisted and was taken by ambulance and police escort because of his previous firearms involvement. Mr. Clark was assessed and was admitted to the Rockyview on June 21st, 2007.

[25] A psycho-social support assessment of Mr. Clark was undertaken on admission. The author, Mr. Clyde Rattan, a mental health clinician, conducted a personal interview of Mr. Clark in Ms. Cousins presence. Mr. Rattan testified Mr. Clark indicated a strong desire to die in the course of the meeting. This, by his interpretation, was different from a person saying they want to take their life and had a plan to carry it out. Even though Mr. Clark didn't express those viewpoints, Mr. Rattan still concluded Mr. Clark's involuntary admission was necessary. Mr. Rattan had a "gut feeling" that Mr. Clarke may potentially be a man who was unsafe and required hospitalization.

[26] Mr. Clark had already told his daughter that he felt unsafe and had rising concerns that something bad would happen to him. Mr. Rattan saw this as a red flag given Mr. Clarke's past history of alcohol abuse, violent behaviour and bipolar disorder. Mr. Rattan saw Mr. Clark to be a suicide risk.

[27] A Form 1 Certificate - formal involuntary admission - was decided upon in conjunction with the on-call psychiatrist, Dr. Elizabeth Wallace.

[28] Mr. Clark was admitted to Unit 48, a 20 bed acute care in patient unit dedicated solely to geriatric patients 65 years of age and older suffering from psychiatric illnesses.

[29] The plan then was for a psychiatric assessment to be done and Mr. Clark's medication adjusted on the expectation that he might be there for at least one month until a full assessment could be completed. Sunnyhill remained an alternative for him once he stabilized.

[30] At that point, Ms. Cousins felt strongly that her father was suicidal. She recognized her father was very good about talking around the issue, offering comments like he would never have the guts to carry out his suicide. She expressed concerns for her father's safety following her experience at the Alberta Hospital where she felt these problems were not being addressed. She was fearful her concerns would not be taken seriously at the Rockyview and that her father would be given too much autonomy.

[31] Mr. Clark was placed in a semi-private room on admission. He was disruptive with his roommate and generally uncooperative. The nursing staff made a decision he needed to be in a private room. A decision was also made for him to be put on a suicide watch.

[32] All of Mr. Clark's possessions were taken from him on admission, his street clothes and belt included and he was put in a hospital gown.

[33] Ms. Cousins found her father back in his street clothes on one of her subsequent hospital visits. He had also requested and was given the return of his belt. Ms. Cousins had been advised his dignity required he be dressed this way.

[34] Ms. Cousins expressed concern to the nursing staff about this turn of events. A nurse informed her they didn't have anything else available other than hospital pants and it was their protocol for patients to have their clothes returned to them. She still felt there was a better solution by her father having sweatpants or some other safe solution. She trusted the staff's judgment and made no demands to reverse the decision concerning the return of his street clothes.

[35] While on Unit 48, Ms. Cousins was convinced her father was saying things to lead the nursing staff to believe he wasn't as much of a risk as he was. He had expressed his torment, confusion and delusions to her several times and in fact told her that he was going to kill himself. She made it clear to the staff he was capable of telling them what they needed to know, that they should read between the lines and should not take everything from him at face value. She expressed strong concerns to the staff that her father was going to kill himself no matter what he might he might say.

[36] Ms. Cousins was never introduced to a primary nurse who had primary responsibility for her father. Responsibility shifted day-to-day dependant on who might then be on shift. Ms. Cousins had no reassurance that information would be communicated to the next nurse on the next shift and in fact had to repeat her concerns from nurse to nurse on occasion. She thought it would assist in having a lead primary nurse central to her father's care, especially in circumstances where she saw her father to mistrust doctors and nurses.

[37] She also expressed frustration in having no control over where her father might be placed but still having all of the discharge planning left for her to do. Dr. Kumar and the social worker would not intervene because her father was switching health regions. Alberta Hospital did not provide a place for Mr. Clark to go nor was the family given direction as to what community resources were available to assist in placing him. They were simply directed to contact their family doctor.

[38] At the time of Mr. Clark's admission, the Unit was staffed during the day by a nursing team of five registered nurses and/or registered psychiatric nurses and one licensed practical nurse. At night, the team was comprised of five registered nurses plus one licensed practical nurse.

[39] Unit 48 is described as a secure unit, the operational portion of which occupies part of one floor of the Rockyview. Patients must be let in and out and there is normally a unit clerk who watches activity at the nursing station.

[40] The physical layout of the Unit is comprised of eight private rooms each housing one patient, inclusive of four private rooms deemed high observation rooms and an additional six semi-private rooms, each housing two patients. Private rooms run along one wall, semi-private rooms at a right angle along the other wall. Mr. Clark's private room was located about mid point near the corner of the floor. A nurses' station, charting and medication areas, offices and operational rooms are located in the mid-portion of the Unit and along the other remaining walls.

[41] Each nurse on the unit carries a caseload of three to four patients per shift. There are three shifts over each 24 hour period. The day shift begins at 7:00 a.m. and ends at 3:15 p.m. The evening shift begins at 3:00 p.m. and continues until 11:15 p.m. The night shift begins at 11:00 p.m. and ends at 7:15 a.m.

[42] Night shift patient observations are normally done on a half-hourly basis. Observation rounds are usually done with two nurses, with each nurse going in opposite directions and then meeting in the middle. The next round is done with each nurse going in the opposite direction from their previous round.

[43] Doctors are available Monday to Friday inclusive. Communication between doctors and nurses on the Unit is either face to face or by notes through the clinical computer system. Nurses receive changes in patient care through doctors' orders left on the computer system.

[44] The Unit employs four levels of close observation of its patients by nursing staff. **"**Constant" observation requires continual observation and monitoring. "Close 1" requires observation every 15 minutes over a 24 hour period until the level is re-assessed and changed. This level requires a nurse either speak with the patient or observe if they are sleeping. **"**Close 2" requires observation every 15 minutes throughout the day and evening shifts, and every 30 minutes throughout the night shift. "Routine" requires observation every hour.

[45] Close 1 observations on Unit 48 are rare. Close 2 observations are predominant. Mr. Clark was under Close 2 observation throughout his entire stay on Unit 48.

[46] During crossover of staff during shift changes, one shift covers the other while a handoff report is being given. One shift informs the next about anything unusual arising in the prior shift. General information is exchanged about all 20 patients, not just specific information about a particular nurse's assigned patients. The charge nurse reads all 20 patients reports. Nurses cover one another's close observations while any one nurse is on a break.

[47] Nurses do not chart every 15 minutes of their observations nor is there any one chart that would show they have seen a particular patient every 15 minutes. Compliance with observation level policy is left to Unit 48 nurses with no policing of staff.

[48] Prior to Mr. Clark's death, patients' belts were a concern if patients were actively suicidal and if they verbalized plans to harm themselves. Mr. Clarke had not expressed this and was not considered actively suicidal.

[49] Mr. Clark's status as a formal patient did not disallow him from being fully dressed in street clothes and being allowed to maintain his belt. Dress was determined by a patient's observation category. Close 1 observation required hospital gowns, Close 2 allowed patients to maintain their own clothes. Mr. Clark's Close 2 status allowed him to maintain his trousers, belt, shoes and shirt.

[50] An informal practice instituted by Unit 48 nurses took hold following Mr. Clark's death requiring belts to be removed at the end of an evening shift and placed in unlocked, assigned cubbyholes at the nursing station located in the medication room. The room is locked when not in use, is monitored and has an access code. Patients were still entitled to return in the morning and request the return of their belts.

[51] Each patient coming onto Unit 48 has a "family systems interview" undertaken. This entails a nurse meeting with family members to learn more about the patient's support system, family, social background and interests which might assist with their hospital stay and planning for their departure. Ms.

Nympha Tham, a part-time staff registered nurse, conducted Mr. Clark's interview and authored the resulting report.

[52] In the course of the interview, Ms. Tham was aware that Mr. Clark was presenting depression and gave the impression he was losing control and expressed a strong desire to die. She did not find that to be alarming nor did she think this made Mr. Clark a suicide risk knowing it was not unusual to see depressive patients possess a desire to die.

[53] The contents of reports following family systems interviews are communicated to nursing staff by the reports being placed on patient's chart with the primary nurse doing any necessary follow up.

[54] Mr. Clark's interview was conducted on June 28th, 2007 but Ms. Tham's completed report was not made available until July 5th, 2007 after Mr. Clark had been sent to the ICU. Ms. Tham was away from the Unit following the interview and did not return to work there until July 5th. There is no protocol for the timing of delivery of the report following a patient's admission other than it being prepared as soon as possible after an interview.

[55] Dr. John Ryan, a psychiatrist and medical director of Unit 48 at the Rockyview was Mr. Clark's primary psychiatrist throughout his admission to the Unit. He signed Mr. Clark's initial Admission Certificate to the Unit for a 24 hour stay. Mr. Clark's watch status had been determined Close 2 by the Emergency Department and was seen by Dr. Ryan to be appropriate.

[56] Mr. Clark's status was determined not to be acutely suicidal while on the Unit. Mr. Clark himself said he would not harm himself because of what that would do to Ms. Cousins, his primary support.

[57] Even though Mr. Clark denied a specific plan of suicide, Dr. Ryan signed a second Certificate allowing for Mr. Clark's ongoing assessment over a further 30 day involuntary stay on the Unit

[58] Dr. Ryan explained an acute suicidal ideation as being symptomatic of someone actively wanting to harm themselves and having a plan to carry out. Suicidal ideation is a softer term used to typify someone's acceptance of death if it were to happen, more of a reflection on their own perception of the quality of their life.

[59] Dr. Ryan explained Mr. Clark's bi-polar disorder, formerly known as manic depression, as being a disorder with two poles of the mental illness. In one pole, the depression aspect, individuals display decreasing concentration, memory, and mood, lack of enjoyment in life, decrease in appetite, weight loss associated with lack of motivation and in the more severe forms, depression. The other pole, the manic aspect, demonstrates the opposite, an individual with excessive behaviours out of keeping with their personality, flamboyancy, excessive spending, use of alcohol or drugs and sexual promiscuity. Mr. Clark's history indicated he had been manic but was more recently demonstrating depression.

[60] Dr. Ryan knew Mr. Clark to be experiencing debilitating side effects from his medications carrying over from the time of his discharge from the Alberta Hospital some 6 weeks earlier. His medication had been adjusted during the two weeks of his stay at the Rockyview with no apparent effect, short of the three to four weeks it might take to see improvement.

[61] The long-term plan for Mr. Clark was to deal with his medications, possibly consider a form of electro-compulsive therapy and stay in contact with members of his family. In Dr. Ryan's view, Mr. Clark's admission likely would have been a three month or more admission, not uncommon for the Unit. In the short time Mr. Clark was on the Unit, they had no chance to develop or carry out a treatment plan.

[62] Dr. Ryan made the observation that in psychiatry, patients tend to be "economical with the truth", with a resulting high index of suspicion for patients by staff.

[63] During the entire course of time Mr. Clark was on Unit 48, Dr. Ryan still did not deem him to be a danger to himself. Dr. Ryan admits it was possible he may not have been telling them about any active plan to become suicidal. But on the other hand, he had no history of suicidal attempts nor expressed any related intentions. Dr. Ryan knew his history from his daughter and knew she was concerned about him. His decision to extend Mr. Clark's involuntary period at Close 2 observation level was done out of precaution.

[64] Dr. Ryan last saw Mr. Clark the day of his death. There was no change in his condition. He hadn't been actively suicidal and didn't voice anything of that sort to staff or other allied professionals.

[65] Dr. Ryan testified that programming for seniors with mental health issues in Calgary is "almost under siege". For the past 12 years including 2007 there has been almost 100% occupancy in Unit 48. There are only 20 of these beds throughout Calgary with Unit 48 at the Rockyview being the only geriatric psychiatric unit in the city. Twenty similar beds at the Peter Lougheed Hospital in Calgary are on hold.

[66] Dr. Ryan is also aware of the availability of the resuscitation team to Unit 48 but is not involved in their efforts. He does not know who on his staff is responsible for co-ordinating any necessary efforts but agrees there are emergency situations with geriatric patients on the Unit and would be worth knowing how to co-ordinate this.

[67] Ms. Lucille Lutz, a nurse and Unit 48's unit manager deals with staffing matters among her other responsibilities on the Unit. She testified at times there have been concerns with the number of nurses available on the Unit but testified they work within their budget and were not understaffed at the time of her testimony.

[68] In specific response to matters related to suicide on the unit, Ms. Lutz testified a unit "educator" is involved in the development of a safety suicide assessment policy. Often new policies and changes would be introduced in training sessions on the unit and during "lunch and learn" training sessions. Attendance at policy orientation sessions for Unit nurses is voluntary with no repercussions for non-attendance.

[69] Policies affecting the Unit are approved at various higher levels and once decided upon, they are "rolled out" to managers and then on to staff.

[70] She testified that there is also no policy requiring a report from a family systems interview appear in a patient's chart right away but there would be verbal communication with staff regarding its important elements. It was not uncommon for a report not to reach the chart for a few days. If suicidal ideation was identified in the course of the meeting, that one fact would be passed on immediately.

[71] Prior to July, 2007, there was no training with respect to "Code Blue" emergencies. After July of 2007 and Mr. Clark's death, Unit 48 underwent a safety review resulting in three broad recommendations contained in Exhibit 5.

[72] The first recommended further educational resources be directed to the staff of Unit 48 focusing on mental health nursing skills including suicide assessment. A "rollout" of the suicide assessment was undertaken verbally with staff. It comprised an explanation including questions and answers surrounding the new policy and inviting staff to attend broader sessions regarding suicide assessment. Various efforts, including lunch and learns were undertaken with the use of other educational materials.

[73] The second recommended a procedure for name alerts to minimize the likelihood of inadvertent error where patients have similar names and ages.

[74] The third recommended mental health in-patient units review their emergency procedures and response plans and consider regular plan drills to assist staff in readiness for such occasions.

[75] None of these recommendations were in place in July of 2007 but some amount of education and training relating to suicide risk assessment remained ongoing.

[76] The recommendations also contained reference to a decision not to alter observation levels.

[77] Ms. Lutz testified each staff member goes through a yearly evaluation with her and the Unit educator to ensure compliance with existing policy.

[78] Ms. Lutz also testified in her view there was nothing to stop a patient who was truly intent on hurting themselves from going to another side of a patient's room and using another patient's belt.

Date and Time of Death

[79] Dr. Susan Kirby was the primary critical care physician caring for Mr. Clark from him reaching the intensive care unit ("ICU") in the early morning hours of July 5th, 2007 until the time of his death.

[80] Dr. Kirby briefly identified the progression of events. Mr. Clark's hanging led to his cardiac arrest which led to his successful resuscitation which led to his eventual transfer into the ICU. He had experienced a significant cardiac arrest and was not doing well upon coming into the ICU. ICU practice usually mandates a wait of 24 hours until more definite decisions are made dependent on neurologic outcome following a cardiac arrest.

[81] Mr. Clark remained relatively stable for a few hours but became progressively more unstable with multisystem organ failure resulting from lack of oxygen during his cardiac arrest. An EEG was done about two or three o'clock the afternoon of July 5th, 2007. A family consultation occurred and Mr. Clark's level of care was changed. His neurologic prognosis was poor and he required an increasing level of support as the day progressed. It became increasingly apparent that Mr. Clark would die. The level of care had then been restricted to comfort measures.

[82] Mr. Clarke died at 7:51 p.m. on July 5th, 2007. He was then 83 years old.

Medical Cause of Death

[83] Ms. Karen Morris, a registered nurse employed on Unit 48, was on duty working the night shift, 11:15 p.m. to 7:00 a.m. on July 4th, 2007. She was one of the staff members during that shift that came upon Mr. Clark on being found hanging in his assigned room. Ms. Morris didn't have specific patient responsibility for Mr. Clark but understood him to be a suicide risk.

[84] When she first entered Mr. Clark's room, she observed one nurse holding Mr. Clark's feet and an LPN from Unit 49 taking off a belt tied around his neck that had been attached to the hinge of what she says was the cupboard door located above Mr. Clark. She recalls a stool to have been located under Mr. Clark's feet. The Code Team was called and arrived shortly thereafter.

[85] The Code Team is comprised of nurses, doctors and respiratory therapists handling emergency crisis situations and is contacted by phoning the operator and asking for a page.

[86] This sort of a code situation on Unit 48 is rare and there is no protocol in place which requires particular staff members to take on particular roles. Nurses on all shifts on the Unit take training once yearly for emergencies but as far as Ms. Morris could recall, there was no training process for emergency situations like this.

[87] Two changes were informally implemented by nursing staff shortly after this incident. First, prior to this event nursing staff used to be regimented about the 30 minute interval rounds being done on the hour and half hour. They now stagger the times. Secondly, patient's belts are now taken away and placed at the nursing desk in a cupboard.

[88] Melissa Johnson, a registered nurse, was on her first Unit 48 shift on July 4th, 2007 just after returning from maternity leave.

[89] In the early morning hours of July 5th, 2007, Ms. Johnson observed Mr. Clark's light on in the course of one of her rounds, entered his room and saw he wasn't in bed. She turned around and found Mr. Clark hanging, she says, from his closet door with his belt wrapped around his neck and a heavy-duty high backed cardiac chair immediately below his feet. She testified these chairs are available on the Unit but are normally are found in other areas closer to the dining area. It was clear to her that Mr. Clark used the chair to get near the upper cupboard. She knew Mr. Clark had last been seen lying in bed awake by other nursing staff. Ms. Johnson charted the event at 1:00 a.m.

[90] She testified that two other nurses arrived to assist her. The Code Team arrived from Unit 49. Ms. Johnson testified she was visibly shaken and upset and handed the situation over to other staff members. A nurse named Kevin from Unit 49 gave Mr. Clark's chart to the Code Team. Ms. Johnson charted the Code Team being called at 1:07 a.m.

[91] Resuscitation was attempted by the Code Team and was successful at 1:28 a.m. At 1:50 a.m., Ms. Johnson spoke with the ICU nurse. Mr. Clark was transferred to the ICU.

[92] Ms. Johnson testified she walked to the ICU with Dr. George Walker but didn't tell Dr. Walker that Mr. Clark had been found hanging and doesn't know whether Dr. Walker was told that he had been found in cardiac arrest.

[93] Dr. Walker runs the coronary care unit at the Rockyview and is responsible for looking after patients within the ICU or coronary care unit. He worked in that capacity in July of 2007 and was the lead physician at the time of Mr. Clark's resuscitation.

[94] Dr. Walker testified that at about 1:00 a.m., he and a team of at least 2 Code nurses, a respiratory tech and a nursing attendant responded to a "Code Blue" pager from Unit 48 which was located about 200 or 250 metres from the ICU. They found Mr. Clark in a hospital bed attached to a machine determining that he had no organized heart rhythm. They commenced advanced cardiac life support and introduced a tracheal throat tube to deliver oxygen and drugs and obtained a blood pressure. About 45 to 50 minutes later, they determined Mr. Clark was sufficiently stable for him to be transferred to the ICU where his condition could be better controlled.

[95] When Dr. Walker first arrived on Unit 48, his initial assessment was that Mr. Clark had been down for some time. He had access to his chart but had no cardiac history. He knew Mr. Clark had a history of alcohol abuse, that he was an ex-smoker and that he was admitted for bipolar disorder but had no further indication of conditions that might have provided more insight.

[96] He was given no information by Unit 48 staff that Mr. Clark had attempted hanging and had no understanding he had attempted suicide until very late, if not completely after the resuscitation. He was satisfied the Code Team did not have the same state of knowledge as the nurses that found Mr. Clark on Unit 48 and were left to assume the situation was a primary cardiac event. Dr. Walker felt it was inappropriate for him not to be apprised of the full circumstances which left him searching for other possibilities. He was both surprised and annoyed when he became aware of the circumstances but testified that still did not change his approach in treating Mr. Clark.

[97] Dr. Walker testified Mr. Clark's vocal cords were suggestive of someone who had been without blood pressure and without oxygen. The lack of oxygen compromised the heart resulting in an irregular beat resulting in the absence of blood flow and blood pressure. The brain was compromised by the initial deprivation of oxygen and then by the lack of blood flow to the brain.

[98] The Medical Examiner's Medical Certificate of Death dated July 6th, 2007 (Exhibit I-1, Tab 1), and the Certficate of Medical Examiner dated November 13, 2007, (Exhibit I-1, Tab 2) bearing Dr. Sam Andrews' signature and Dr. Kirby's "Death Summary" summarizing the events while Mr. Clark was under her Unit's care (Exhibit I-1, Tab 4,) were all entered in evidence.

[99] On all of the evidence before this Inquiry including the evidence summarized under the heading "Manner of Death" immediately following, I conclude the medical cause of Mr. Clark's death to be hanging.

Manner of Death

[100] Nancy Teghtmeyer, a Unit 48 registered psychiatric nurse saw Mr. Clark on July 3rd, 2007 by. At 7:20 a.m., Ms. Teghtmeyer charted Mr. Clark's affect to be flat and that he was reclusive to his room. At 2:40 p.m. the same day, she noted she had undertaken a mental health assessment by questioning Mr. Clark and noted he denied any thoughts of self harm or suicide ideation. She explained the practice to be that nurses question patients about thoughts of suicide or self harm. She testified that if the patient answers "no", they take the patient's word for it.

[101] At 7:20 a.m. on July 4th, 2007 Ms. Teghtmeyer charted Mr. Clark to show flat affect and that he commented that "I've never felt worse". She testified Mr. Clark was clear in referring this related only to his sleep. She understood him to be a suicide risk but not actively suicidal. Her observations gave her no concern his suicide risk had increased. On July 4th, 2007, her sense of Mr. Clark was that his suicide risk had decreased by him making efforts to come out of his room and socialize and by him saying he was hopeful his medication changes would help him.

[102] Sarah Rau, a student nurse charged with Mr. Clark's care along with Unit's primary nurse, testified to the process of observing Mr. Clark on his Close 2 watch. She interpreted this to mean that Mr. Clark had to be seen every 15 minutes to observe but not necessarily interact with him. Charting required noting his mood, affect, diet, sleeping patterns, interaction with staff and people on the unit. She understood there might be an issue of self harm or suicide with Mr. Clark, just as there was with every other patient on the unit.

[103] Ms. Rau's last interaction with Mr. Clark was on July 4th, 2007. She had no specific concerns about him at that time. She referred to her charting note of 7:30 p.m. which showed Mr. Clark's response to her question of how he liked a walk they had taken by him answering "there would be no need to do it again". Her experience with Mr. Clark was that he used sarcastic tones and would make offhand

comments throughout her entire interaction with him. She didn't see his comments to be out of character.

[104] Ms. Rau's charting note of 9:00 p.m. also showed Mr. Clark to be "in room looking in closet".

[105] Ms. Morris was the last to chart Mr. Clark's activities prior to him being found hanging in his room. At 11:30 p.m. on July 4th, 2007, she noted she saw Mr. Clark awake in bed. She testified that Mr. Clark was awake, seemed calm and settled and not in any distress. She testified she had requested him to let them know if he was awake during the night and needed anything so they could accurately record how his sleep was. He responded "okay". She observed nothing different from her previous encounters with him other than to say he was usually asleep on her initial rounds and wasn't often awake at that time of the night.

[106] Ms. Morris had just come on the night shift at 11:15 p.m. that evening and commenced her first round of the night. She testified that night charting occurs twice only, once on the initial round and then in the morning at around 6:00 or 6:30 a.m. The remainder of the 30 minute observations are done on a checklist but do not form part of a patient's chart and are done simply to keep track of 30 minute intervals. Those checklists are not preserved.

[107] At 1:00 a.m. on July 5th, 2007, Ms. Johnson charted that she found Mr. Clark hanging in his closet. She then charted the "Code Blue" Team was called at 1:07 a.m. and Mr. Clark was transferred to the ICU at 1:50 a.m. She also charted that Mr. Clark was last seen awake in bed at 12:30 a.m., not 11:30 p.m. on July 4th,' 2007 as earlier charted by Ms. Morris.

[108] Whatever the precise timing between the nursing staff's last observation of Mr. Clark and the time he was found hanging, there is clear evidence that Mr. Clark was found in the early morning hours of July 5th, 2007 hanging by a belt attached to a hinge on a closet door with a heavy duty high backed hospital chair placed immediately below his feet. There was no evidence suggesting Mr. Clark was somehow physically limited in his ability to move and climb onto the chair to position himself as he was found nor was his age shown to be a factor.

[109] Mr. Clark was not watched constantly throughout his stay on Unit 48. As a matter of practice, his observation in the late hours of July 4th, 2007 and the early morning hours of July 5th, 2007 would have occurred every 30 minutes. The evidence shows Mr. Clark had a window of opportunity to organize his own suicide between the time Ms. Morris last charted her observations of him and the time Ms. Morris's co-worker and the Unit 49 nurse first found him hanging as charted by Ms. Johnson at 1:00 a.m., July 5th, 2007.

[110] At the time of his death, Mr. Clark had reacquired and was entitled to possession of his own belt. There is no evidence Mr. Clark possessed or had access to any other patient's belt, but the possibility existed given Unit policy. The evidence demonstrates at the very least that Mr. Clark had full access to his own belt prior to him being found hanging in his room in the early morning hours of July 5th, 2007.

[111] There was no evidence of foul play in relation to Mr. Clark's death nor could a reasonable inference be drawn which might lead to that conclusion.

[112] Based on all of the evidence in this Inquiry, the inference may logically and reasonably be drawn that Mr. Clark hung himself using the belt found around his neck tied to a hinge on the closet door in his assigned room accomplished by his positioning and then climbing onto the hospital chair located below his feet.

[113] In my view, Mr. Clark's long history of psychiatric problems culminated with the occurrence of this one tragic event. There is a sufficient foundation of direct and circumstantial evidence to conclude that Mr. Clark's death was suicidal.

RECOMMENDATIONS

Recommendation 1:

[114] Ms. Lutz's evidence establishes that observation levels established by the Calgary Health Region's Mental Health Policy (Exhibit I-1, Tab 21) were made effective October, 1998. At the time of Mr. Clark's death, minor revisions to those observation levels were made under the Calgary Health Regions Mental Health & Addictions Services Policy (Exhibit I-1, Tab 11) and were under consideration along with a "Suicide Risk Assessment" bearing an effective date of April 2007 (Exhibit I-4). The only difference in the description of observation levels in the revised policy related to the description of Close 1 observation levels. No other alterations were recommended and particularly, no alterations were proposed to Close 2 observation levels. Those materials were still under consideration over the summer and into the fall of 2007, the period overlapping Mr. Clark's death.

[115] After Mr. Clark's death in July, 2007, Unit 48 underwent a safety review resulting in three broad recommendations (Exhibit I-5). The recommendations contained reference to a decision not to alter observation levels, justifying that position by saying all former health regions were being moved under one health region with the expectation that this likely would present future opportunities to harmonize all departmental policies across the province.

[116] Mr. Clark's death occurred under Close 2 Observation Levels Policy No. I-1.1 which had last been revised, reviewed and harmonized between the years 2000 and 2003. Any opportunity to look critically at the effectiveness of observation levels under which Mr. Clark's death occurred was delayed by the results of a safety review following his death which by its own terms, set aside a review of close observation levels pending re-organization of health regions.

[117] The effect of the efforts to amend observation levels (Exhibit I-1, Tab 11) coupled with the results of a safety review that followed Mr. Clark's death (Exhibit I-5) which suggests harmonization of observation levels at an undetermined future time, leaves important issues unresolved.

[118] The evidence in this Inquiry demonstrates Mr. Clark was entirely successful in circumventing formal hospital efforts to avoid self harm through periodic observation by nursing staff. Observation levels employed in Unit 48 and other similar psychiatric units in Alberta must be critically reviewed and restructured.

[119] **I recommend an immediate re-evaluation of the structure, application and usefulness of current Observation levels and practices as are now employed on Unit 48 at the Rockyview and as may be employed in all other similar acute care psychiatric units throughout the Province of Alberta. As a starting point and pending the outcome of this evaluation, I recommend times between observations currently deemed to be Close 1, Close 2 and Routine be significantly shortened.**

[120] **Following that review, I further recommend that a renewed Observation protocol be implemented on Unit 48 and on all other similar acute care psychiatric units throughout the Province of Alberta where the same or similar Observation levels and practices to those used on Unit 48 are employed.**

Recommendation 2:

[121] The evidence is clear that prior to Mr. Clark's death, a patient's attire on the Unit was dependent upon a psychiatric assessment and was tied to a patient's level of observation. After Mr. Clark's death, Unit 48 nursing staff established their own informal policy such that belts would be retrieved in the evening, stored and locked in a central location and made available to patients upon request the next morning.

[122] Mr. Clark's access to a belt facilitated his death. There are alternatives. Paper belts or elastic waistbands are just two possibilities. Neither a patient's dignity nor safety would be compromised by implementing some very simple changes.

[123] Belts, of course, are only one of many pieces of apparel or furnishings on a psychiatric unit that could be used to implement a patient's suicide. After all is considered, it may be that street clothes pose just too great a risk to patient safety and are not appropriate in this setting.

[124] Dr. Ryan testified that even if a person presented some form of danger to himself or others, there is no policy mandating all such patients remain in hospital clothes. He also testified that there is no assessment or policy to determine appropriate street attire. Whatever clothes the patient wears on admission are the clothes they continue to wear on the Unit.

[125] Dr. Ryan referred to his experience on both sides of the Atlantic in relation to the issue of hospital clothing. His experience has been that for the most part patients remain in their street clothes on psychiatric units unless they are deemed to be high observation level. The complaints hospital staff receive from patients on these Units is that they feel they're incarcerated and have everything taken from them. Efforts are made to accommodate patients to make them feel as normal as possible as a result.

[126] Dr. Ryan was not aware of any other jurisdiction where there policies exist relating to the clothing issue but is certain there must be, citing the United States as a possibility.

[127] I listened carefully to Dr. Ryan's testimony. While he did not explicitly say so, I was left with the impression he considered the issue of proper hospital clothing on psychiatric units, geriatric or otherwise, to be an old, persistent and unresolved issue in the psychiatric community. That debate should be put to rest.

[128] **I recommend as a matter of policy that belts be taken from patients on admission to Unit 48 at the Rockyview and all other similar acute care psychiatric facilities in Alberta and those items be retained in safekeeping, night and day, over the full duration of a patient's admission.**

[129] **I further recommend the inherent dangers in clothing worn by patients on those units be examined and a uniform safety policy be adopted in relation to patient clothing. That policy should include, but not be restricted to, identifying and employing alternatives to clothing deemed to be unsafe, belts included.**

Recommendation 3:

[130] Unit 48 is unique to the extent it is the only such unit in Calgary. It is used to capacity nearly all of the time. The evidence in this Inquiry supports a finding that fail safe monitoring of psychiatric patients by nurses may, for all practical purposes, be difficult if not impossible to achieve. Nursing staff must be assisted in their efforts with the sole objective of enhancing patient safety.

[131] In making the recommendations that follow, I fully recognize Unit 48 is far from being a remand center or correctional facility. In my view, valuable lessons in dealing with the needs of “at risk” psychiatric patients can still be learned from other settings where continual television monitoring occurs for reasons of safety and security.

[132] I understand Unit 48’s physical layout comprises a portion of a hospital floor in a separate contained area. The Unit appears to be well suited to being monitored from a central location. Technology has a place in achieving that result.

[133] **I recommend the installation of 24 hour central monitoring of patient rooms and common areas in Unit 48 at the Rockyview using real-time onsite video cameras.**

[134] **I further recommend that system be evaluated by Unit 48 administrators and nursing staff within 6 months of its installation and that evaluation be provided to Alberta Health Services to consider the installation of similar systems in other similar acute care psychiatric units throughout the Province of Alberta.**

Recommendation 4:

[135] Ms. Lutz offered one recommendation in that there be increased support for her staff who work in a challenging environment. I also heard a recommendation from Mr. Clark’s family that more education be made available to all front-line workers, physicians, nurses, psychiatric nurses and licensed practical nurses included. I also heard evidence concerning the current availability of continuing education for Unit 48 staff on the topic of suicide and suicide prevention.

[136] Ms. Johnson expressed an opinion that everything that could have been done was done to avoid Mr. Clark's death. She also commented that cameras can't watch patients all the time and if patients want to kill themselves, they will. Ms. Rau did not react to Mr. Clark's suggestion of not needing to go for another walk and looking vacantly into his closet as sign posts to further behaviour. Ms. Tham saw nothing alarming about Mr. Clark's expressed desire to die just days before he did, as was contained in her report and which comment was not made available on Mr. Clark's chart until after his death. Mr. Clark's family are troubled by those comments knowing the outcome. They see the absence of education to be a contributing factor to these attitudes.

[137] The evidence showed existing efforts to provide continuing education to staff nurses on Unit 48 appears, by all accounts, to be *ad hoc* and elective with no incentive for staff to fully participate. Nurses on this and other similar psychiatric Units in Alberta should be given the full opportunity to enhance and refine their assessment and communication skills. Improvements in those skills will only translate into a safer environment for patients.

[138] **I recommend regular, mandatory and rigorous continuing on site education and training relative to suicide and suicide assessment and prevention be provided to all Unit 48 nursing staff and nursing staff in other similar acute care psychiatric facilities elsewhere in the Province of Alberta.**

[139] There is insufficient evidence for me to extend this recommendation to other disciplines, particularly as it might relate to the education of physicians or other professionals and I therefore decline to do so.

Recommendation 5:

[140] Dr. Walker expressed concern about not knowing the fact of Mr. Clark's hanging at the time of the arrival of the resuscitation teams. Members of the Unit 48 nursing staff knew of the event but it was not communicated to the resuscitation team until well after the fact.

[141] Dr. Walker also expressed concern that Mr. Clark's desire not to be resuscitated on facing the code status he did was unknown to his team. Dr. Walker stated that there are four "goals of care" alternatives: Level I - full resuscitation; Level II - limited resuscitation; Level III – supply comfort only, and Level IV, a level reserved for organ donation but no information appeared on Mr. Clark's chart. Dr. Walker testified for he and the Code Team to restrict the level of resuscitation would have required a legal document. In its absence, the decision presumes Level I, the position that Dr. Walker understood Mr. Clark to be in. Dr. Walker testified that not knowing the code status created a medical dilemma, especially when it later became clear that Level I resuscitation was not in the patient's plans. The resuscitation team was obliged to continue active treatment until another decision was made, even in the face of Mr. Clarke's poor prognosis.

[142] Ms. Wendy Clark, Mr. Clark's middle daughter testified she and her sister attempted to inform doctors that their father's wish was not to be on life support but supporting documents had been left at home. She couldn't understand the doctors continued attempts to use these measures when they saw it to be contrary their desire to allow their father to die peacefully without the trauma they saw him undergoing.

[143] **I recommend an immediate review and reorganization of all internal procedures that result following a patient emergency on Unit 48 at the Rockyview. This should include but not be restricted to a review and reorganization of the manner in which ICU is activated by Unit 48, the manner in which it and Unit 48 are expected to respond and the manner in which a patient's history, intended goals of care and reasons for patient transfer are communicated between Units.**

[144] **I further recommend that a resulting comprehensive emergency protocol between those Units be implemented.**

Recommendation 6:

[145] Ms. Lutz testified to the process that was followed on Unit 48 immediately following Mr. Clark's death. Mr. Clark was found at night while most patients were sleeping. The decision was made in collaboration with the on-call psychiatrist that patients would not be informed that a death on the Unit had occurred but rather would be informed the patient was no longer in his room and had been transferred to another unit. Patients in Unit 48 never learned of Mr. Clark' death through staff. There was unanimity amongst psychiatrists on the Unit that patients be told Mr. Clark had been transferred because of the decline in his condition. Over the next couple of days, patients continued to ask nurses when Mr. Clark was returning. The message continued to be that he had been transferred to another unit. All individual psychiatrists had been informed and were dealing with their individual patients but staff were told not to inform patients there had been a death. The thought was that message would be unnecessary and would only upset patients.

[146] The evidence demonstrates that at any given time, many, if not all of Unit 48's patients may be potential suicide risks. It is reasonable to assume patient response to the news of a death or other stressful situation involving fellow patients might be unpredictable. Any resulting danger of self harm posed to patients on Unit 48 or other similar psychiatric units on learning of the death or other emergency involving a fellow patient must be minimized.

[147] **I recommend an immediate review and reorganization of all post-emergency procedures on Unit 48 at the Rockyview which shall include a full review of the manner in which emergencies are communicated to remaining patients, particularly in circumstances where a death has occurred.**

[148] **I further recommend that a related comprehensive post-emergency protocol be considered and implemented on Unit 48 and in other similar acute care psychiatric facilities elsewhere in the Province of Alberta.**

[149] Dr. Kumar expressed frustration in seeing seniors placed in the community in these sorts of circumstances, considered by him to be a daunting task in the midst of scarce resources. I acknowledge his recommendation that a "seniors advocate" of sorts be named to champion the cause of seniors in avoiding placement in acute care hospitals where other facilities may be better suited. In that same context, I also acknowledge the frustration expressed by the Clark family in having their father's difficult situation assessed and then not being able to locate a proper placement for him.

[150] The jurisdiction of this Inquiry to make recommendations is limited to those which might prevent similar deaths. On the entire body of evidence before me, I must respectfully limit my recommendations to those already referenced without further addressing the concerns expressed in the preceding paragraph.