RELEASE DATE: February 20, 2014

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***The Fatality Inquiries Act*****, C.C.S.M. c. F52**

AND IN THE MATTER OF: An Inquest into the Death of:

Ann Hickey

Report on Inquest and Recommendations of
Judge R. L. Pollack
Issued this 14th day of February, 2014

APPEARANCES:

Ms Carli Owens, Counsel to the Inquest;
Mr. Izzy Frost and Mr. Eli Goldenberg, Crown Counsel on behalf of Manitoba Development Centre, Department of Family Services and Labour, Government of Manitoba;
Ms Beverley Froese and Ms Aimée Craft, Counsel for People First of Canada and People First of Manitoba

RELEASE DATE: February 20, 2014

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52

REPORT BY PROVINCIAL JUDGE ON AN INQUEST INTO THE DEATH OF:

ANN HICKEY

Ann Hickey is the full name of the deceased. She was born on July 4, 1959 and came to her death on March 29, 2011 in the Portage District General Hospital in Portage la Prairie, Manitoba. She lived for forty-one years in remarkable care at the Manitoba Development Centre in Portage la Prairie. Having held an inquest into her death, this is my report.

Ann Hickey's death was caused just before midnight on March 25, 2011 by strangulation while she was in her wheelchair in a common room at MDC. This came about from the pressure of her wheelchair seatbelt on her neck, resulting in bronchopneumonia due to hypoxic encephalopathy.

This report contains my essential findings and recommendations after having reviewed the evidence and written submissions provided by inquest counsel and counsel for the parties. It contains a list of witnesses who testified and a series of exhibits that were admitted into evidence. I had the benefit of having the evidence presented by counsel who were extremely well prepared and thorough and this report will not reflect all of their hard work, for which I am grateful.

Pursuant to the provisions of subsection 33(3) of *The Fatality Inquiries Act*, I am ordering that all exhibits be returned to the Exhibit

Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Winnipeg, in Manitoba, this 14th day of February, 2014.

"Original signed by:"

Judge R. L. Pollack

Copies to: Dr. A. Thambirajah Balachandra, Chief Medical Examiner
Chief Judge Ken Champagne, Provincial Court of Manitoba
The Honourable Andrew Swan, Minister of Justice
Ms Carli Owens, Counsel to the Inquest;
Mr. Izzy Frost and Mr. Eli Goldenberg, Crown Counsel on behalf of Manitoba Development Centre, Department of Family Services and Labour, Government of Manitoba;
Ms Beverley Froese and Ms Aimée Craft, Counsel for People First of Canada and People First of Manitoba

BACKGROUND

[1] The Manitoba Development Centre ("MDC") is a provincial residential institution accommodating Manitobans whose developmental disabilities make it exceptionally difficult if not impossible for them to live in the community. It is a government institution under the auspices of the Department of Family Services. Ann Hickey had been an MDC resident for forty-one years.

[2] This Inquest is required by the provisions of subsection 19(3) of *The Fatality Inquiries Act, C.C.S.M. c. F52*:

> **Inquest mandatory**
>
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> > (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in The Mental Health Act, or while a resident in a developmental centre as defined in The Vulnerable Persons Living with a Mental Disability Act, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> >
> > (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

[3] On September 29, 2011 Dr. A. T. Balachandra, Chief Medical Examiner ("CME") directed an inquest to be held:

a) to fulfill that mandatory requirement;

b) "to determine the circumstances relating to Ms. Hickey's death";

c) "to determine what, if anything, can be done to prevent similar deaths from occurring in the future".

[4] The authority to conduct an inquest and the scope of an inquest are circumscribed by the provisions of *The Fatality Inquiries Act*. It is succinctly set out in the CME's direction to hold an inquest. A judge has no authority to go beyond that and subsection 33(2) of the *Act* states that an inquest judge:

> (b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

Therefore this inquest was not to determine wrongdoing, to appraise MDC as a health care institution or to scrutinize government health care philosophy.

[5] While some of the evidence may be of interest to a party wishing to study the broader topics surrounding MDC, this inquest is about how Ann Hickey died after she was out of sight in a wheelchair that was equipped with a seatbelt. She had slipped down so far that the seatbelt became tight across her neck. She was found 2011in that state just before midnight on March 25, without a heartbeat. Although a pulse was restored with resuscitation, nothing more could be done for her. She remained in palliative care in hospital until March 29, 2011 when a medical decision was made to end the use of life support systems.

[6] After notice was given to the public, a hearing was held on March 22, 2012 to enable applicants to apply for standing at the inquest. Upon hearing representations from Manitoba Justice Civil Legal Services on behalf of MDC, I granted MDC standing as a party to the inquest. Upon hearing representations from Public Interest Law Centre counsel on behalf of People First of Canada and People First of Manitoba, I granted People First of Canada standing as a party to the inquest. Particulars of the parties' standing included the ability to present evidence, to examine or to cross-examine witnesses and to make submissions.

[7] There is a member of Ann Hickey's family living elsewhere in Canada. Her relative was informed about the inquest by the CME and inquest counsel. At my request, inquest counsel kept that person informed about the proceedings.

[8] The inquest hearing was preceded by meetings with inquest counsel as well as organizational meetings in my office. Counsel for People First of Canada and People First of Manitoba were included in those organizational meetings and that led to their application for standing. Attached as *Appendix A* is a list of witnesses and the dates upon which I heard their evidence in a Provincial Court hearing room at 75 Tupper Street North in Portage la Prairie, Manitoba. Attached as *Appendix B* is a list of exhibits that I admitted into evidence.

[9] The hearings commenced on May 6, 2013 and I note, not parenthetically, that senior MDC staff members were surprised at the delay in holding this inquest. They expected an inquest but they did not hear anything official until the fall of 2012. This was a lengthy proceeding and, in Provincial Court, the available hearing dates were a function of the Court's caseload, judicial resources and courtroom management. (Further information in that regard is available in the Annual Report of The Provincial Court of Manitoba *(www.manitobacourts.mb.ca)*).

[10] The evidence consisted of witness testimony and a series of exhibits. During the hearings in Portage la Prairie I had an opportunity with counsel to view the Westview area of MDC. The last witness was heard from on June 4, 2013. The parties wished to be heard after all of the evidence was in and I decided that their representations should be submitted in writing on a fixed date; counsel indicated that they wished to obtain transcripts to assist in preparation and it was agreed that all submissions would be filed by September 1, 2013.

[11] As a result of a technical issue with one of the daily transcripts, I extended that time to September 25, 2013 and submissions arrived that day. MDC counsel claimed the right to make further submissions; none was forthcoming but, on October 15, 2013, MDC counsel requested a further time extension and tendered as part of the evidence a letter confirming recent accreditation to MDC. I gave the other parties an opportunity to respond and, in the absence of hearing any objection, included the document and considered the inquest closed.

HOW ANN HICKEY PRESENTED AT MDC

[12] Ann Hickey was admitted to MDC on January 12, 1970; she was ten and one half years old. A birth injury left her in profound mental retardation. She suffered from epilepsy, hypothyroidism and osteoporosis. She was there because she required significant resources to assist her with ordinary life skills, health care, socializing and – importantly - personal safety.

[13] The diagnosis "profound mental retardation" implies an IQ lower than 25 and intellectual functioning ability that is so low it is practically immeasurable. While Ann Hickey could show preferences, she had no

ability to participate verbally or otherwise to communicate in a reliable way with staff. She was completely dependent upon them for feeding, dressing and toileting. Dr. Michael Stambrook, a distinguished forensic psychologist retained by MDC, described her as someone "in a persistent state of unawareness".

[14] Her other diagnoses complicated the situation for staff. In addition to her seizure disorder and osteoporosis, she suffered deep vein thrombosis - blood clotting in her lower extremity. She endured a number of falls. She suffered a number of skin conditions that would have caused her itching and other discomfort, from bed sores to cold sores. It is not surprising that she had difficulty sleeping.

[15] Despite her cognitive disabilities, Ann Hickey certainly did communicate her preferences to those who were able to spend sufficient time with her. Known as "Annie" to her staff, she was found to have a fierce independence of spirit, a sense of humour, likes and dislikes. The inquest testimony, when observed in the hearing room, was checkered with facial expressions and body language, and some tears, demonstrating that Annie's presence was remarkable and she is surely missed.

[16] Over the years Ann Hickey lived in different areas of MDC. She had a history of falling, in part due to seizures and, early in 2011, consideration was being given to a transfer. There was concern for her frequent falling and staff felt that Westview, with its wider corridors and doorways, and no steps, would be better for her.

HOW ANN HICKEY PRESENTED AT WESTVIEW

[17] In late February, 2011 she suffered a fractured vertebra after bumping into another resident. Until then she had relied upon a wheelchair for outings but, provided that she was supervised (for safety), she was able to walk. This injury changed things and made transfer to Westview an emergency decision.

[18] She continued to be treated for her various ailments with medications containing substances such as cortisone and antihistamines which interfered with her ability to sleep. She was bruised and in pain and taking an analgesic known as Tylenol 3; it contains enough codeine to have a sedating effect and it causes the discomfort of constipation. My clear

impression is that there were all kinds of things that irritated her and it must have been difficult for her to relax and fall asleep unless she was tired.

[19] It was up to MDC to facilitate her transfer to Westview. When that decision became an emergency decision, however, a detailed transition policy was not followed. What this meant for Ann Hickey and the Westview staff was that she was transferred without a transition plan, meaning that she was transferred without specific individualized instructions.

MARCH 25, 2011

[20] The increased use of a wheelchair aggravated edema in her legs. Because her doctor was concerned about increased rashes and bruising he recommended that she use special stockings. Interestingly, on March 25, 2011 physiotherapist Jonathan Tiessen thought that she was making progress in walking. His opinion was that, with supervision, she should be walking and this would also address the concern about her edema. He made a progress note to that effect.

[21] Although her ability to ambulate had improved and staff did not want her to be using a wheelchair, there were seating requirements for her dining chair under consideration. The use of some kind of tray that was tantamount to a restraint was being considered and that kind of decision is only made in consultation with family, substitute decision makers and careful consideration of human and legal rights. But there was no discussion ongoing about a wheelchair seatbelt because they were trying to do away with her wheelchair.

[22] That afternoon physiotherapists discussed the state of Ann Hickey's edema and the need for her to increase her mobility and spend less time in a wheelchair. Nurse Brian Crawford was the night nursing manager at Westview. He spoke with the residential coordinator about keeping her as mobile as possible. In the "communication book", which is used to brief incoming shift members at a shift change, he wrote:

> And should be permitted and encouraged to walk around the area as much as possible. Sitting for long periods of time with her feet down in Broda chair or in wheelchair is very detrimental to her health. She should also be encouraged to sit in her recliner with her footrest down and the chair in front of her, to put her feet on. This is so she does not try to get up with the footrest up and fall. Try to keep an eye on her,

> but her risks of falls is less than her need to be mobile and have her feet up.

This would have been included in his briefing of the staff who came on at 11:00 P.M.

[23] So, as of March 25, 2011, there were two seating efforts being addressed: getting Ann Hickey walking without her wheelchair but using a special dining room chair which may have entailed a restraint.

[24] During the afternoon of March 25, 2011, Ann Hickey was not using her wheelchair. She was seen walking about and sometimes sitting in a recliner, a chair which enabled her legs to be elevated. Nurse Crawford had noticed that, prior to 7:30 P.M., she was walking the hallway. Shortly thereafter, however, she was found on a washroom floor by two psychiatric nursing assistants ("PNA"s). They had to assist her not only to get up but to get dressed and she was not too cooperative.

[25] The PNAs had many routine tasks in looking after about twenty residents; Ann Hickey had no routine other than to be permitted to stay out of bed until she became tired. To enable themselves to go about those duties they decided to place her in a wheelchair. Her wheelchair was not where it was supposed to be and it could not be found. Another was appropriated and she was placed in it. While it is not clear when, at some point the seatbelt of that wheelchair was fastened around her.

[26] It is an expectation and a requirement of MDC that residents use their own wheelchairs unless a wheelchair is out of service. If that happens, the fact that a resident is in a substitute wheelchair must be recorded and communicated. That Ann Hickey was not in her own wheelchair was neither documented nor reported; therefore the night shift PNAs were not informed.

[27] By March 25, 2011 Ann Hickey had become quite capable of propelling her Westview wheelchair with her feet. It is apparent that she was able to manoeuvre up and down the hallway on her own. As staff went about their evening duties they saw her from time to time, always in the wheelchair, thus avoiding the risk of falling to the floor and being in the situation in which she was earlier found.

[28] At the 11:00 P.M. shift change three PNAs were assigned to Westview. PNAs are not medically trained. They are a specialized kind of

health care aid. Their normal duties include personal resident care, housekeeping and assisting nurses and therapists. In MDC they participate in therapy programs for residents and report on them. They are expected to familiarize themselves with each resident's individualized Care Guide.

[29] An MDC Care Guide is a chart of information and instructions generated by *Momentum*, a software program for medical and senior staff. In addition to briefings when coming on shift, PNAs are expected to consult the communication book containing handwritten notes from the previous shift, much of which will have been covered in the briefing.

[30] Because of a shortage elsewhere that evening, the supervisor had to reassign one of those PNAs to a different area. The evidence indicated that this is not an unusual occurrence. Westview is known as an area that is usually quiet and not so taxing, once residents were asleep, that one PNA cannot be spared.

[31] Around 11:30 P.M. Ann Hickey was the only resident who was not yet in bed and staff were following the instruction that she should not be taken to bed until she appeared sufficiently tired. They went about their other duties but had occasion to notice her in the hallway in her wheelchair. It was probably about 11:40 P.M. when she was observed by staff at the end of a hallway that terminates in a large room called the South Day Hall. Standing at its entrance one can see into the South Day Hall both to the left and to the right; if one stands further up the hallway, however, parts of the room disappear from view. The nursing office is quite a bit further up that hallway.

[32] When the two PNAs last saw Ann Hickey near that South Day Hall, they were standing near the nursing office. At that point two things happened: an alarm sounded indicating that one of the residents had moved out of bed and the phone rang. One answered the phone and the other attended to the alarm.

[33] The PNA who responded to the alarm had to reposition a resident and tuck her blanket in because that is what sounded the alarm. She emerged from the room and, not seeing anyone, headed in the direction of where she had last seen Ann Hickey. It was only when she got to the South Day Hall that Ann Hickey came into view in the far left corner of the room. She was actually seated in front of her wheelchair with the seatbelt

tight around her neck holding her upright. About fifteen minutes had elapsed since the bed alarm sounded and the phone rang.

[34] The PNA undid the buckle of the seatbelt and realized that the woman was not breathing. She called for her colleague who checked for a pulse while she started compressions. A supervisor was called and an ambulance was summoned. Several staff continued the compressions until paramedics arrived.

[35] Although Ann Hickey's heart continued to beat, the strangulation resulted in her death on March 29, 2011 when life support was withdrawn under the supervision and authority of a doctor. Compassionate MDC staff made sure that she would not be alone in palliative care.

RESIDENT DATA FOR THE PNA

[36] Ann Hickey had been living on Westview for about a month. The nature of MDC scheduling meant that the March 25, 2011 night shift PNAs would have seen her less than once per week. They received a briefing when they come on shift at 11:00 P.M. but, perhaps because her transfer was made on an emergency basis, the briefing did not include involving the PNAs in a specific transition plan. And there was no activity plan other than she could continue wandering about in her wheelchair until she was tired. Of course the PNAs had access to the Care Guides and communication book entries.

[37] The state of her Care Guide on March 25, 2011 did not indicate that the therapist felt that she ought not to be in a wheelchair. It is a single-spaced three-page document in which boxes contain notes for each heading. This is what the notation looked like to anyone reviewing that Care Guide; under the heading "Mobility", a large box at the bottom of the first page:

> PREFERENCES AND CHOICES, ANNIE PREFERS BARE FEET. SHE CONSTANTLY REMOVES HER SHOES AND SOCKS. Xray reveals a recent possible T12 fracture (Feb 24/11). Resident shows increased willingness to ambulate since last assessment (March 25, 2011), and does note appear to be in pain., Ambulatory, RESIDENT FAVOURS LEFT FOOT/LEG, Supervision for walking in room, Setup help only for walking in room, UTILIZES WHEELCHAIR WHEN OFF AREA, Supervision for walking in corridor on residential area, Setup help only for walking in corridor on residential are, Ambulates w/ transfer belt plus physical support from staff, STANDBY ASSIST AMBULATING TO DINING HALL AND BATHROOM, Likes legs elevated when sitting, Shoes and socks to be worn when going off area, and socks constantly, Elevate legs when sitting/sleeping, Dependant on Wheelchair at this time for comfort and safety due to fractured T12. Recieved Broad chair ON LOAN from Rehab services to use for comfort until able to comfortably return to sitting in her manual one, Uses manual wheelchair, One person physical assist for wheelchair use on unite, to utilize arjo lift with green or blue sling, Requires someone to push wheelchair, Ensure foot pedals in use, Seat-belt while in wheelchair, Monitor for sliding in wheelchair, No preferences and choices,., Supervision for transfers, Setup help only for transfers, Transfer belt, Cue resident before & during transfers

[38] Although there was a note that she did not appear to be in pain, Ann Hickey was taking Tylenol with codeine to manage her back pain. The statement that she depended upon her wheelchair was contradicted by Nurse Crawford's communication that using a wheelchair was detrimental to her health. She demonstrated that she did not require anyone to push her wheelchair. Although it is found under the "Safety" heading at the top of the third page, the contents of this box must be considered as well:

> Unaware of personal dangers, Risk for falls, Risk for choking, Requires full siderails, Seatbelt while in wheelchair

[39] From the instruction "monitor for sliding in wheelchair" under "Mobility" and the statement "seatbelt while in wheelchair" under "Safety" it is not clear that sliding was a safety concern and certainly there is no hint that sliding was life threatening.

[40] There is a history of Ann Hickey attempting to reposition herself in her wheelchair. She has been described as squirming and causing her stomach to be pushed up by the seat belt. No one has described her actually being able to slide out of the seatbelt and there has been no other recorded instance of her being able to slide so far that the seatbelt reached her neck. Her favourite sitting position was to bring her knees up and cover

them with the upper clothing she was wearing. She had been seen to unfasten the aircraft-style buckle but this appeared to be random and not an acquired skill. PNAs would be aware of this from their own observations, briefings and communication entries as well as the Care Guide.

[41] One of those who were involved in decisions about Ann Hickey's mobility was Nurse Brian Crawford. He and therapists were involved in a seating clinic that determined, after a detailed examination of a host of factors found in a multi-page form, what kind of wheelchair and other seating was best. But the concern about her sliding in her wheelchair was a note from 2010 when she used a different chair that was larger and required someone to push her. The clinic had decided to give her a smaller chair that she was able to manoeuvre on her own. Her ability to do so was quite evident on the evening of March 25, 2011.

[42] At this point it is necessary to consider not only how confusing the "Mobility" box is but how the use of the verb "to monitor" at MDC was never an exercise in precision. Obviously the "Safety" section ought to have been front-and-centre and MDC has done something about that. The monitor instruction in the "Mobility" box is in the nineteenth line of the single-spaced box. It is not capitalized or otherwise emphasized and it is found among contradictory information.

[43] The Care Guide is populated with data from entries in *Momentum* which are neither in a consistent format nor necessarily up to date because obsolete entries survived. The result is the jumble mixture found in the "Mobility" box.

WHAT "MONITOR FOR SLIDING IN WHEELCHAIR" MEANT

[44] Regardless of what the foregoing observations imply, the PNAs who found Ann Hickey unable to breathe just before midnight on March 25, 2011 did not know that she should be monitored for sliding in her wheelchair. They have testified that the instruction was not found in the Care Guide. I have no reason to doubt their credibility; certainly they were not wilfully trying to mislead when they insisted that the sentence was not there.

[45] What I can understand, against the background of the Care Guide excerpt and all of the evidence, is how those PNAs could be left with the belief that there was no such instruction because none would have forgotten it. I do not think that they saw it and, even if they had, it is not clear that there would have been constant eyes on Ann Hickey. And there is no evidence of anyone having seen her trying to reposition herself in the wheelchair that night.

[46] A PNA with 14 years of experience at MDC testified that monitoring meant to make more frequent checks of a resident, more frequent than the thirty minutes which is normal. She did not understand monitor to have a fixed meaning. A PNA with a 2002 Health Aide Certificate from Red River Community College, and four years of experience at MDC, agreed and suggested that she would check on someone she was monitoring two or three times within that half hour.

[47] A PNA with just two years of experience testified that monitoring meant to pay close attention to something. When asked by Inquest counsel if she could relate that to a time frame, she pointed out that it would depend upon the individual because “everyone perceives it a little differently”. She thought that fifteen minute checks would be a typical response to a monitoring instruction.

[48] A PNA who had been working at MDC since 1978 spent most of her time as a “floater” on nights. She took monitoring to be a general term, meaning to keep an eye on a resident for a particular reason. She gave one example of a resident with a fever requiring Tylenol who would be monitored every two hours.

[49] A nurse with 33 years of experience said, “I did not like the term monitor because it was too broad of a term”. It was his view that more precision should be used such as “check vital signs in so many hours” or “have a staff within a few feet of (a resident)”. To this nurse, monitor was just a convenient word in popular use.

[50] A PNA with thirty years of experience described monitoring - in the context of the Care Guide requirement that a resident was in a wheelchair and required monitoring – to mean that the resident should be watched getting out of the wheelchair or perhaps sliding in the wheelchair. Monitoring did not mean constant observation unless the guide stated that.

[51] A Licensed Practical Nurse ("LPN") with eight years of experience looked at Ann Hickey's Care Guide and was quite specific in stating that she would maintain visual contact while she was walking but, in her wheelchair, felt that the standard of every fifteen minutes satisfied the monitoring requirement. Another LPN testified that, if there was an instruction to monitor someone in a wheelchair, she would expect all of the staff to be aware of this and there would be checks every fifteen minutes because staff were unable to be "side by side all the time". She made this interesting response when asked if it would be better for an instruction to spell out how many minutes there should be between observations:

> I think that as nurses we know what that word means and we know that we need to be checking on it. And spelling it out would almost be an insult.

[52] Nurse Crawford, who inserted the instruction, said that his expectation of monitoring Ann Hickey for sliding in her wheelchair meant that incidents of her sliding would be reported.

INVESTIGATIONS

[53] MDC is a professionally run institution that takes on huge responsibility for residents with severe disabilities. As recently as October 3, 2013 its accreditation was renewed by the Council on Accreditation ("COA"), a body chosen by MDC because its standards suited its requirements for objective evaluation. Indeed, an immediate report to COA of a critical incident like this one is required. And MDC has in place a protocol for commencing an immediate investigation into a fatality and reacting to such an investigation by making improvements (which they have done and continue to do).

[54] Barbara St. Goddard is the Director of Habilitation and Specialty Programs at MDC and Cynthia Winram is its Chief Executive Officer. It is Ms. St. Goddard's job to be the investigation chair for resident protection issues and she began her work within hours of the admission of Ann Hickey to hospital. She arranged for written statements to be taken from all of the staff on duty on both the afternoon and evening on March 25, 2011.

[55] What the investigation did not include was an examination of either the fatal wheelchair or Ann Hickey's wheelchair or a consultation with the

occupational and physio therapists about those chairs. One of the reasons given by Ms. St. Goddard was that the report had to be prepared quickly. She and other senior staff testified that they were under pressure from Carol Youngson, a CME investigator, from the moment Ann Hickey passed away. She described it as being at the Medical Examiner's "beck and call" in terms of putting together information about Ann Hickey, her health care history (including the February 16, 2011 fractured vertebra) as well as the events of March 25, 2011.

[56] Even after the report was prepared, however, the resident experts on wheelchairs at MDC were not consulted about the difference between the chairs and whether those differences were significant to the investigation. Obtaining a wheelchair for an MDC resident is not like buying a pair of runners. The seating clinic works through a multi-page questionnaire and makes determinations such as what the seating areas are made of, the firmness necessary, required measurements and other minutiae that go into making a wheelchair safe. There are differences between the two wheelchairs and no steps were taken to preserve the wheelchair in the state in which it was found nor was an analysis of the difference between the chair in which Ann Hickey died and her own chair performed.

[57] The investigation report comes to a good conclusion – that MDC should address how risk-related information is communicated to its staff – but it contains erroneous information. It contains the finding that the two wheelchairs "are very similar in terms of the height of the chair, depth of the seat and the style of the seatbelts". While that may seem to be the case, a greater depth of analysis would have cast doubt on that statement. This error is compounded in the conclusion that being in a different wheelchair "had no bearing on her sliding down in the wheelchair in which she was found, as she had a history of sliding down in her own wheelchair and both wheelchairs are very similar".

[58] Another finding was that the occupational therapists were considering using a pelvic strap to reduce the risk of sliding in the wheelchair. Had they been consulted, the investigators would have been told that this proposal concerned only a dining chair. And otherwise they wanted Ann Hickey walking, not using the wheelchair. It is clear from the evidence of Ms. St. Goddard that she was not aware of the importance of the errors in her report or the significance of not consulting a wheelchair expert until just before she testified.

[59] Carol Youngson was not a witness. From the evidence of Ms. St. Goddard and Ms. Winram, I infer that she did not conduct an investigation other than to obtain information from MDC. She completed a document called Preliminary Report of Death but it is really just a sketch of a narrative of how Ann Hickey was found, the medical intervention and some other information from MDC. Ms. Youngson's report is dated March 30, 2011 although I note that Ms. Winram was continuing to send her information by facsimile the following day. Why it was necessary for the CME investigator to rush the MDC investigators is not clear. (The Preliminary Report of Death repeats the innacuracy about the similarity of the wheelchairs. It also states that MDC staff "discourage" Ann Hickey from walking because "she is somewhat unsteady on her feet". I do not know how Ms. Youngson came to that conclusion as the evidence is clear that her walking was to be encouraged.)

[60] The 911 call prompted a response from the Portage la Prairie Royal Canadian Mounted Police ("RCMP") detachment as well as an ambulance. They arrived at the same time - three minutes after midnight. RCMP officers spoke to the PNA who found Ann Hickey and her colleague who helped attempt resuscitation. Statements were obtained almost immediately from the two witnesses and thereafter the police investigation appears to have been limited to collecting documents from MDC and the CME.

[61] I refer to these other investigators (*i.e.* the CME investigator and RCMP) because they, too, took no steps to preserve the evidence of the wheelchair in the condition in which it was found or the clothing Ann Hickey wore that night. Whether that might have yielded helpful scientific results was obviously never considered.

[62] More importantly, there is no evidence of the seatbelt measurement as it was found by the first PNA. That might have yielded evidence of whether the seatbelt of the wrong wheelchair was nevertheless tightened to an appropriate circumference. Most importantly, there is no expert analysis of the differences between the wheelchairs and the relevance, if any, of those differences to the investigation.

SOME ESSENTIAL FINDINGS

[63] No one from the afternoon shift passed on the information to anyone on the night shift that Ann Hickey was not in her own wheelchair. The two PNAs who remained on Westview for the night shift were not only unaware of the wheelchair but they were also unaware of Ann Hickey's tendency to slide in her wheelchair or that this was a safety issue. Additionally, they had no programming instructions for her other than to let her remain awake in her wheelchair. And they had jobs to do, alarms to respond to and phone calls to answer.

[64] The tragedy occurred when Ann Hickey was alone in the South Day Room. She could only have been seen by someone standing at the end of the corridor at the Day Room entrance. There is not a scintilla of evidence to suggest that anyone else was present when she encountered distress. That happened between approximately 11:40 and 11:55 P.M.

[65] The tragedy was treated as an accident and it was not investigated with the same discipline as a suspected crime scene or a suspected unsafe workplace. In that regard this inquest was at a disadvantage.

RECOMMENDATIONS ABOUT THE CARE GUIDE

[66] Dr. James Gardner is an American expert in systems that measure quality of life for the disabled and systems that measure how well their care-givers deliver services. Much of his testimony went beyond the scope of this inquest (and I have something more to say about that) but I found his perspective on how MDC operates helpful. He reviewed all of the disclosure provided by the CME, MDC and inquest counsel and produced a report. The report is wide-ranging; it deals with threshold matters like the very philosophy of MDC's resident-centred care and particular matters like meeting minutes.

[67] Part of Dr. Gardner's testimony concerned the differing observations of Ann Hickey's behaviour that he noted:

> The, the importance of that found in the difference that people observed different things, the importance is that there appears to be no process for

> resolving differences, that I could find. So an observation is that she is using a wheelchair, she's not using the wheelchair. She's uncomfortable in the wheelchair, she is comfortable. These could all be very valid observations on the same day or, of course, two different days. But I didn't find any evidence that that interdisciplinary team came together and said: So, what have we got here? Is she comfortable in the chair, or is she not comfortable. I, I don't know who is responsible, or if anybody is, for making those determinations.

Dr. Gardner's evidence was presented by counsel for People First of Canada. She pointed out that there was evidence at the inquest of interdisciplinary discussion of issues:

> Q And Dr. Gardner, we did hear evidence from the nursing staff and, and others that they did have discussions about safety and weighing the risks. You mentioned you didn't see any evidence of that in the documents. And so I'm wondering, you know, in light of this evidence that we've heard at the hearing, is that there were discussions. What kind of documents would you expect to see, how, to document those kinds of discussions?
>
> A I would expect to see something, I mean, this is the type of document that belongs in the interdisciplinary assessment place of an individual service plan. That the professionals met, we discussed this issue. This is, this has huge implications for the ethics of the decision and the safety of the person. So there's got to be a professional documentation. How are you we going to communicate this, the consideration and then the decision? I mean, the two staff were on that night weren't even aware that there was a problem here. So, I guess, the discussion was, was fairly limited.

[68] While I do not consider the inquest's function to include exploring the "implications for the ethics of the decision", I do consider an analysis of how MDC communicated its expectations of staff to be of significance. And the fact remains that the PNAs on duty on March 25, 2011 did not understand that the plan was to get Ann Hickey out of her wheelchair, recovering from her fractured vertebra and leg edema by walking more. And they certainly did not understand that she was in danger of strangling herself in a strange wheelchair.

[69] At the risk of putting too fine a point on it - it is clear that neither the Care Guide nor any progress note or other communication prevented the MDC investigators from making erroneous findings.

[70] MDC has made improvements to its resident Care Guides. The "Safety" box is now at the beginning and it should be the first thing that the reader notices. All of the Care Guide boxes are important. They are filled with menu-driven comments from those who input data and the "Mobility" box that I have referred to demonstrates how automation can be counter-productive if it allows for the presence of obsolete, contradictory and illogical inputs. There appears to be random emphasis in upper case letters: "ANNIE PREFERS BARE FEET" in the first line and "Monitor for sliding in wheelchair" three lines from the bottom; "PREFERENCES AND CHOICES" at the top and "No preferences and choices" at the bottom.

[71] MDC has undertaken a "communication survey" and intends to improve how staff communicates. As I understand it, monitoring will now include a frequency instruction so that staff will know with precision what is expected of them. This is important because it appears that the PNAs are the ones, in addition to residents, who will really benefit from more precision. Precision also requires consistency in everything from language to font size.

[72] **It is therefore recommended:**

That MDC produce Care Guides that give information and direction to PNAs with utmost clarity by:

(1) examining its Care Guides and identifying variations in entries that mean the same thing;

(2) adopting a suitable uniform standard instead of those variations such that the reader will have unequivocal statements of fact and instruction;

(3) scrutinizing its Care Guides and deleting contradictions perpetuated by obsolete data.

[73] **It is further recommended:**

That MDC examine its automated data entry software and take such steps as are necessary to change it or replace it:

(1) to enable input to resident Care Guide entries according to a suitable uniform standard;

(2) to enable obsolete data to be identified and deleted;

[74] Care Guides and other communications are provided in hard copy binders to PNAs. They are accessible on an office shelf. Surely it is time to enable PNAs to carry an electronic volume in their pockets. (I edited part of this report on a tablet currently available for less than $200.00.) This, combined with an improved format and standardized entries, would go a long way to improving communication.

[75] The suggestion emerged during the hearing that PNAs be able to input Care Guide data. I accept that there are valid reasons not to grant every care-giver those credentials. That said, it would be comforting to know that a PNA observing a resident sliding in a wheelchair had the instant opportunity to log that observation for the benefit of the medical, therapy and management staff. This is how to collect intelligence about trends and cycles in the institution as well as specific resident issues. It is what Dr. Gardner was talking about when he was questioned about how to reconcile differing observations of the same person:

> .....that's the purpose of data, so that we take data to establish patterns of when people are appearing to be comfortable or uncomfortable, when they're using the wheelchair, when they're not. So it isn't your observation, your observation or somebody else's observation. But over time, we have a dozen observations and we can make some conclusions based on data. I mean, this, it seems to me these data based decisions are the basis of quality assurance and quality improvement programs.

[76] **It is therefore recommended:**

That MDC:

(1) enable all staff to have portable electronic access to Care Guides and other relevant resident information;

(2) enable all staff to log observations, information and suggestions electronically.

RECOMMENDATION ABOUT CONTINUING TRAINING

[77] There are basically two types of manuals for staff: those containing MDC policies and those explaining equipment. For the latter, on topics such as wheelchairs, MDC holds refresher training every three years. For policies, the binders are made available and staff members are told when changes are made in a communication book note.

[78] **It is recommended:**

That MDC management hold periodic policy workshops for staff, scheduled in such a way that no staff member attends a policy workshop less than once every twelve months, with an agenda that includes an opportunity for staff input on policy issues.

RECOMMENDATIONS ABOUT RESIDENT TRANSFERS

[79] MDC has in place a method of proposing a transfer in writing which includes the reasons, a profile of the individual and factors including risk assessment. That was happening in this case even before Ann Hickey took her last fall. But her emergency transfer left all protocol behind, as Dr. Stambrook testified:

> There was probably insufficient charting on the transitional process. On the salient issues relevant for her traditional process, such as and importantly and vitally, the probably three areas of safety risk which were most important: number 1 - seizures, number 2 - falls and number 3 - the sliding that she did that inevitably led to her death. So those were issues that probably systemically in terms of safety issues on a transfer from a unit that knew her to a unit that was going to get to know her, they should have been highlighted in a very significant way.

[80] **It is therefore recommended:**

That the MDC resident transfer policy require written advice as to safety risk factors in the case of any transfer, regardless of any exigency, to accompany the resident and be provided to all staff on duty immediately and to be logged in a source to which future staff will be directed.

RECOMMENDATIONS ABOUT WHEELCHAIRS

[81] MDC has taken steps to make sure that wheelchairs are legibly tagged with the owner's name. It has a policy in place that, if a resident is in an alternate wheelchair, that will be charted and communicated. That is a good start but, taking cognizance of the disabilities of MDC residents, there are some further simple steps to be taken.

[82] **It is therefore recommended**:

That MDC require a highly visible tag or label to identify for its staff:

(1) that a wheelchair is not the user's own wheelchair;

(2) that a wheelchair user is at risk for repositioning.

[83] **It is further recommended**:

That therapists include in the Care Guide a statement whether or under what circumstances a resident must be kept in constant view when walking, using a wheelchair or other assist.

RECOMMENDATIONS ABOUT INVESTIGATIONS

[84] There can be no criticism of the emergency response: a supervisor was notified, a 911 call was placed and resuscitation was commenced. But MDC has to ensure that there will be proper investigative response to sudden deaths and other critical incidents. Its primary purpose is not to find fault or to place blame; to investigate critical incidents like this one is to take a step toward prevention of another occurrence. A good starting point might be a meeting with Carol Youngson (whose experience is well documented in other inquest reports).

[85] **It is therefore recommended**:

That MDC, in consultation with police and other resources such as the CME and the Workplace Safety and Health Branch, establish an investigative protocol for gathering evidence of critical incidents, preserving it to enable analysis

to be done and obtaining the results for its investigation reports.

A NOTE ABOUT DR. GARDNER'S INPUT

[86] Dr. Gardner's report and testimony, in addition to analyzing critically the death of Ann Hickey, prompts interesting discussion about MDC and its mission. It prompted submissions from People First of Canada that would have taken this report beyond its mandate under *The Fatality Inquiries Act*. It would be a shame, however, if Dr. Gardner's "systems guy" analysis (a description unanimously applied by counsel) was not looked at from time to time as MDC continues to work on improving its policies and operations and maintaining its accreditation.

Dated at the City of Winnipeg, in Manitoba, this 14th day of February, 2014.

"Original signed by:"

_____

Judge R.L. Pollack

Appendix "A"
To the Inquest Report into the Death of Ann Hickey

DATE:	WITNESS:
May 6, 2013	Sarah Smith
	Cathy Modd
May 7, 2013	Valerie Bullock
	Terry D. Safruik
May 8, 2013	Joanny Spruyt
	Brian Crawford
May 9, 2013	Katrina McDonald
	Amanda Green
	Melanie Lavallee
May 13, 2013	Peggy Larson
May 14, 2013	Harold Robert Martens
May 15, 2013	Kristin Roy
	Brenda Solomon
	Linda Lehmann
May 16, 2013	Michele Roteliuk
	Barbara Susan St. Goddard
May 27, 2013	Jonathan Edward David Tiessen
	Cynthia Winram
May 29, 2013	Dr. James F. Gardner
June 4, 2013	Dr. Michael G. Stambrook

Appendix. "B"
To the Inquest Report into the Death of Ann Hickey

FILED AS:	COURT MONITOR DESCRIPTION OF EXHIBIT:
Ex. A	MDC General Policy and Procedures Manual
Ex. B	Inquest Documents that will be referred to during the process of the inquest
Ex. C	Curriculum Vitae and job description of Sarah Smith
Ex. D	Curriculum Vitae and job description of Cathie Starr
Ex. E	Curriculum Vitae and Job Description of Valerie Bullock
Ex. F	Curriculum Vitae and Job Description of Terry Safruik
Ex. G	Curriculum Vitae and Job Description of Sherry Ward
Ex. H	Curriculum Vitae and job description of Joanny Spruyt
Ex. I	Curriculum Vitae and job description of Brian Crawford
Ex. J	Floor Plan
Ex. K	Referral made by Brian Crawford
Ex. L	Curriculum Vitae and Job Description of Katrina McDonald
Ex. M	Curriculum Vitae and Job Description of Amanda Green
Ex. N	Curriculum Vitae and Job Description of Melanie Lavallee
Ex. O	Curriculum Vitae and Job Description of Karen Nicholls
Ex. P	Curriculum Vitae and Job Description of Peggy Larson
Ex. Q	INTERNAL RESIDENT TRANSFER PROPOSAL
Ex. R	CARE GUIDE ANN HICKEY March 8, 2011
Ex. S	COMMUNICATION OF INFORMATION SURVEY
Ex. T	Curriculum Vitae and Position Description of Harold Martens
Ex. U	Curriculum Vitae and Job Description of Kristin Roy
Ex. V	Curriculum Vitae and job description of Brenda Solomon
Ex. W	INCIDENT NOTES
Ex. X	Curriculum Vitae and job description of Linda Lehmann