RELEASE DATE: December 29, 2015

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:

HEATHER DAWN BRENAN

Report on Inquest and Recommendations of
Judge Margaret Wiebe
Issued this 22nd day of December, 2015

Appearances:

Mr. D. W. Coward, Counsel for Dana Brenan
Ms. Keri Anderson, Crown Counsel
Mr. E. William Olson, Q.C., Counsel for Winnipeg Regional Health Authority and Seven Oaks General Hospital
Mr. William G. Haight, Counsel for Dr. Allen MicFlickier
Mr. G. Todd Campbell, Counsel for all doctors (except Dr. MicFlickier)
Mr. Jacob Giesbrecht, Counsel for Manitoba Association of Health Care Professionals

RELEASE DATE: December 29, 2015

Manitoba

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

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

HEATHER DAWN BRENAN

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 was extremely well prepared and though this report will not reflect all of their hard work, I am grateful for their assistance.

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 22nd day of December, 2015

Original Signed by
Judge Margaret Wiebe

Copies to: Dr. T. Balachandra, Chief Medical Examiner

Chief Judge Ken Champagne, Provincial Court of Manitoba

The Honourable Gord Mackintosh, Minister Responsible for *The Fatality Inquiries Act,* Minister of Justice and Attorney General

Ms. Julie Frederickson, Deputy Minister of Justice and Deputy Attorney General

Ms Lorraine Prefontaine, Director, Specialized Prosecutions

Mr. Russ Ridd, Director, Regional Prosecutions

Mr. Michael Mahon, Assistant Deputy Attorney General, Prosecutions Division, Manitoba Justice

Ms Jacqueline St. Hill, Director, Winnipeg Prosecutions

Ms. Keri Anderson, Crown Counsel

Mr. D. W. Coward, Counsel for Dana Brenan

Mr. E. William Olson, Q.C., Counsel for Winnipeg Regional Health Authority and Seven Oaks General Hospital

Ms. C. Tolton, Counsel for Winnipeg Regional Health Authority

Mr. William G. Haight, Counsel for Dr. Allen MicFlickier

Mr. G. Todd Campbell, Counsel for:

i. Dr. Stanley Whyte
ii. Dr. Neil Swirsky
iii. Dr. Mark Schneider
iv. Dr. Susan Phillips
v. Dr. Paul Dowhanik
vi. Dr. Bojan Paunovic
vii. Dr. Ricardo Jorge Lobato de Faria
viii. Dr. Alecs Chochinov

Mr. Jacob Giesbrecht, Counsel for Manitoba Association of Health Care Professionals

Exhibit Officer, Provincial Court of Manitoba

Ms. Aimee Fortier, Executive Assistant and Media Representative, Provincial Court of Manitoba

Manitoba

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

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

HEATHER DAWN BRENAN

TABLE OF CONTENTS

I. **Distribution List**:

1) Dr. T. Balachandra, Chief Medical Examiner
2) Chief Judge Ken Champagne, Provincial Court of Manitoba
3) The Honourable Gord Mackintosh, Minister Responsible for *The Fatality Inquiries Act,* Minister of Justice and Attorney General
4) Ms. Julie Frederickson, Deputy Minister of Justice and Deputy Attorney General
5) Ms Lorraine Prefontaine, Director, Specialized Prosecutions
6) Mr. Russ Ridd, Director, Regional Prosecutions
7) Mr. Michael Mahon, Assistant Deputy Attorney General, Prosecutions Division, Manitoba Justice
8) Ms Jacqueline St. Hill, Director, Winnipeg Prosecutions
9) Ms. Keri Anderson, Crown Counsel
10) Mr. D. W. Coward, Counsel for Dana Brenan
11) Mr. E. William Olson, Q.C., Counsel for Winnipeg Regional Health Authority and Seven Oaks General Hospital
12) Ms. C. Tolton, Counsel for Winnipeg Regional Health Authority
13) Mr. William G. Haight, Counsel for Dr. Allen MicFlickier
14) Mr. G. Todd Campbell, Counsel for:
    i. Dr. Stanley Whyte
    ii. Dr. Neil Swirsky
    iii. Dr. Mark Schneider
    iv. Dr. Susan Phillips
    v. Dr. Paul Dowhanik
    vi. Dr. Bojan Paunovic
    vii. Dr. Ricardo Jorge Lobato de Faria
    viii. Dr. Alecs Chochinov
15) Mr. Jacob Giesbrecht, Counsel for Manitoba Association of Health Care Professionals

16) Ms. Aimee Fortier, Executive Assistant and Media Representative, Provincial Court of Manitoba

17) Exhibit Officer, Provincial Court of Manitoba

II. Mandate of The Inquest

Inquests in Manitoba are governed by *The Fatality Inquiries Act* (the *Act*), and are presided over by judges of the Provincial Court of Manitoba. The duties and limitations of a judge presiding at an inquest are set out in s. 33 of the *Act*. The primary role of the judge at an inquest is to determine the identity of the deceased, when, where, and by what means, the deceased person died, the cause of death, the material circumstances under which the death occurred and whether the death could have been prevented. Further, a judge may recommend changes in the programs, policies or practices of the government and relevant public agencies or institutions or in the laws of the province, where the judge is of the opinion that such changes would serve to reduce the likelihood of deaths in similar circumstances in the future.

There is a statutory limitation placed on a judge presiding at an inquest in Manitoba. Section 33(2) of the *Act* prohibits a judge from expressing any opinion on or making a determination with respect to culpability in respect of the death that is the subject of the inquest. In other words, a judge at an inquest is not permitted to make a finding or express an opinion that someone is responsible for or legally blameworthy in the death of the person that is the subject of the inquest.

The mandate of this inquest is to determine the material circumstances relating to Heather Brenan's death and to determine what, if anything can be done to prevent similar deaths from occurring in the future.

III. Holding of The Inquest

[1] On February 4, 2013, pursuant to s. 19(1) and s. 19(2) of the *Fatality Inquiries Act*, the Chief Medical Examiner of the Province of Manitoba called an Inquest into the death of Heather Brenan. The specific questions to be addressed at the Inquest are:

a) To determine the circumstances relating to Heather Brenan's death;

b) To examine the hospital policy regarding hospital discharge of patients at night, particularly those are elderly, frail and who reside alone;

c) To examine hospital acute bed situation in Winnipeg; and

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

[2] A standing committee hearing was held on January 27, 2014, and standing was granted to the parties who ultimately appeared at the hearing.

[3] The hearing was held between May 11, 2015 to June 10, 2015. Submissions by the parties were made on June 24, 2015. A total of 25 witnesses testified over the course of the 12 days of hearing.

IV. Introduction

[4] At the time of Heather Brenan's death, she was a 68-year-old woman who lived alone in the city of Winnipeg. Her daughter, Dana Brenan, lived in England. Heather Brenan had several medical issues. On January 24, 2012, she was brought to the Emergency Department ("ED") at the Seven Oaks General Hospital ("SOGH") by a friend complaining of weakness and difficulty swallowing. She had suffered a substantial weight loss since December, 2011. Heather Brenan remained in hospital from January 24 to 27, 2012. During that time, she was cared for by well over 20 health care providers. She was never admitted to a ward. Heather Brenan was discharged on January 27, 2012 at 10:35 p.m. and was sent home to meet a friend who had the keys to her home.

[5] Heather Brenan arrived home in a taxicab and was dropped off in her back lane. She collapsed at the doorway of her home and was brought back to the ED of SOGH shortly after midnight on January 28, 2012. Heather Brenan was resuscitated in emergency and was transferred to the Intensive Care Unit ("ICU"). Her condition continued to deteriorate and Heather Brenan died on January 28 at 11:55 a.m.

[6] The questions set out by the Provincial Chief Medical Examiner will be examined in this report, including SOGH policy at the time of and following Heather Brenan's death. The Courts recommendations are made throughout the report.

[7] The medical care Heather Brenan received will be set out in detail for two reasons. First, to give Dana Brenan and Heather Brenan's family and friends a clear picture of her care. Second, because detailing the care by the various doctors, nurses, specialists and Allied Health Care workers, sets the stage for the analysis of the questions posed by the Chief Medical Examiner.

V. Heather Brenan – Who She Was

[8] Heather Brenan was a 68 year old woman who lived in Winnipeg all of her life. She married as a young woman and by 1963, she and her then husband had moved in with her mother. Heather Brenan had one child, Dana Brenan. Dana Brenan lived with her parents at her grandmother's home and then with her mother and grandmother from the age of one (1), as Heather Brenan's husband had left by that time.

[9] Heather Brenan had spent her entire career working at the Winnipeg Free Press. She started at age of 21 and remained there until her retirement at the age of 62. Heather Brenan started out as a Teletype worker at the Winnipeg Free Press and then became a journeyman.

[10] As a mother, it is apparent she was very close to her only child, Dana Brenan. Dana Brenan moved to England and resided there for 25 years. While there, her mother continued to be interested in her academic pursuits and Heather Brenan typed and edited academic papers for Dana Brenan. They kept in close contact, talking on the phone every Sunday, and later in life several times a day. They had a good understanding of what was going on in each other's life.

[11] Heather Brenan had a love of gardening, baking and driving her car. From the testimony of Dana Brenan and her friends, Ms. Nayda Northage and Ms. Gail Thompson, it was clear that Heather Brenan was a very friendly and social individual. Heather Brenan regularly attended family gatherings and was proud to bring her contribution of her elaborate baking to any gathering.

[12] Ms. Northage was her good friend. They had been co-workers and friends since 1989. They worked together on union issues and were both on the bargaining committee. They socialized and went to events together. The two of them spent a good amount of time together and Ms. Northage continued to visit Heather Brenan up until September, 2012, when Heather Brenan's mobility issues started to interfere with her ability to get around. They did however, continue to talk on the phone often, sometimes up to 20 times a day. Ms. Northage talked of Heather Brenan's love of gardening and driving, and she painted a picture of a very independent and caring woman who was very thoughtful and kind to her friends.

[13] Ms. Thompson also testified. Ms. Thompson told the Court she had known Heather Brenan for about 34 years. They met and worked at the Winnipeg Free Press together for many years. Over the last 10 or 11 years of Heather Brenan's life, while they did not see each other, they spoke to each other on the phone almost every day. It was clear they had a close friendship.

[14] A number of Heather Brenan's caregivers at the SOGH also spoke about Heather Brenan's friendly, charming personality.

VI. Heather Brenan's Medical Issues Prior to Arriving at SOGH ("SOGH")

[15] Dr. Renu Bhayana was Heather Brenan's family physician for many years. Although she did not testify, a letter dated May 11, 2015 was filed outlining Heather Brenan's health status historically and just prior to her attending at SOGH. Dr. Bhayana indicated Heather Brenan suffered from obesity, hypertension, arthritis, and diabetes. Shortly before her death, she was diagnosed with arterial fibrillation. Dr. Bhayana placed her on medication - Pradaxa, a blood thinner, for the arterial fibrillation.

[16] Dr. Bhayana indicated on December 8, 2011, Heather Brenan first complained of throat pain shortly after she ate food. Heather Brenan was concerned she had a blockage in her throat. Dr. Bhayana arranged for her to have a gastroscopy with Dr. Allan Micflickier, which was done on January 2, 2012. Dr. Bhayana last saw Heather Brenan on January 24, 2012, when she recommended she attend at SOGH Emergency.

[17] Dana Brenan testified that in late September or October, 2011, she had spoken to her mother and her mother said that she had gone to see her family doctor, Dr. Bhayana, as she had lost 10 pounds. She advised Dana Brenan, that she was not eating as much as she had in the past. By Christmas time, Heather Brenan advised Dana Brenan that she thought she had a hiatus hernia and she was on medicine, but it did not appear to be working. She told Dana Brenan that she did not feel like eating and there was a bubble in her esophagus that bothered her every time that she tried to swallow.

[18] Heather Brenan advised Dana Brenan that she was going to see Dr. Micflickier for a gastroscopy. Heather Brenan was concerned they would confirm the hiatus hernia or they would discover cancer. She reported to Dana Brenan after the gastroscopy and said that, other than a bit or redness, they did not find anything. She would have to return to the doctor at another time for a biopsy.

[19] Ms. Northage confirmed Heather Brenan had health issues prior to her attendance at SOGH. She said Heather Brenan had two knee surgeries somewhere around the age of 60 or 61. After that time, Heather Brenan was more home bound and did not go out as much as she had in the past. She said Heather Brenan did do her own grocery shopping every Saturday. Around September, 2011, the grocery shopping had become much more difficult for her and this continued right up until the time of Heather Brenan's hospitalization. Ms. Northage said that Heather Brenan had slowed down within her own home by the fall of 2011. In September, 2011, Heather Brenan had telephoned her and said she was having difficulties

swallowing and she felt a bubble in her throat. Between September and December of 2011, Heather Brenan had advised Ms. Northage that she had difficulty eating soup and mashed potatoes and said she was only able to sip water. She also advised Ms. Northage that she had an appointment with Dr. Bhayana on January 24, 2012 and asked Ms. Northage to drive her. This was significant to Ms. Northage, as Heather Brenan was a fiercely independent woman and usually drove herself.

VII. Heather Brenan's Course of Treatment at SOGH

[20] Ms. Northage took Heather Brenan to see Dr. Bhayana on January 24, 2012. Ms. Northage said Heather Brenan had difficulty walking to and from the car to the doctor's office from a short distance away. The walk took Heather Brenan 20 minutes each way. Once Heather Brenan re-joined Ms. Northage, she said her doctor told her to go to the hospital right away. Ms. Northage drove Heather Brenan back to her house to pack a bag and then drove her to SOGH.

[21] At the hospital, Ms. Northage said the triage nurse checked Heather Brenan's oxygen level. Because it was low, they moved her into emergency. Ms. Northage's concern, as she communicated it to the triage nurse, was Heather Brenan had not eaten and she was unable to eat. She felt strongly the hospital needed to provide nourishment to Heather Brenan.

[22] Dr. Stanley Whyte was the ED doctor who made the decision to admit Heather Brenan to SOGH. Dr. Whyte finished Medical School at the University of Manitoba in 1992 and then he did a rotating internship with the University of Toronto and St. Michael's Hospital from 1992 to 1993. He has been continuously employed as an Emergency Physician at SOGH since 1993.

[23] Dr. Whyte testified he worked the 10 a.m. to 10 p.m. shift on January 24, 2012. At that time of the day, there are two Physicians working in the ED. In addition, there is a Physician's Assistant on staff. In this case, it was Sandy Schreider. He described a Physician's Assistant as someone with either military training or someone who has gone through the University of Manitoba's Physician Assistant course. A Physician's Assistant is considered to be at the level of a first year medical resident. They are people with experienced knowledge in medical practice but they do not practice independently. Rather they practice under the supervision of a Physician.

[24] Ms. Schreider had done an undergraduate degree and completed the University of Manitoba two-year program of full time study to become a Physician's Assistant. She was a new graduate and started at SOGH on January 1, 2012. Ms. Schreider did not testify; however, she was interviewed and her evidence was agreed to and admitted by consent of the parties.

[25] Ms. Schreider examined Heather Brenan before Dr. Whyte saw her and she reported her findings to Dr. Whyte. In addition to examining Heather Brenan, she also filled out the Advance Care Form. She does not recall the specific discussion with Heather Brenan or who was present. She believes the form was filled out after Heather Brenan had a chest X-ray, which disclosed a mass, and before she had the chest CT. Ms. Schreider said the form reflected Heather Brenan's wishes at that time. The Advance Care Form indicated Heather Brenan wanted full resuscitation, including cardio pulmonary resuscitation ("CPR").

[26] Once Ms. Schreider presented her results to Dr. Whyte, he examined Heather Brenan himself. Dr. Whyte agreed with Ms. Schrieder's assessment, her investigations and her plan for treatment.

[27] Dr. Whyte reviewed the information on the Emergency Treatment Records which said: Heather Brenan presented as a 68 year old female with a past history of Type 2 diabetes, high blood pressure, low thyroid, anemia, kidney stones, gout, osteoarthritis, renal failure, bilateral total knee replacement, and complaining of weakness. Heather Brenan had difficulty swallowing, she had nausea, she was dehydrated and she had experienced a 40-pound weight loss since December, 2011. The Emergency Treatment Record indicated Heather Brenan had been sent to Emergency by her family doctor to be assessed.

[28] Dr. Whyte believed Heather Brenan was dehydrated. She also had low blood pressure and a fast heart rate. His impression was that she was in need of a fluid resuscitation and accordingly, he ordered saline boluses of fluid to address her dehydration. In addition, Dr. Whyte ordered a number of tests including blood work, an EKG and a chest X-ray. The blood work was to confirm whether Heather Brenan was dehydrated, which it did confirm. It was also to determine whether she was anaemic. The EKG was to determine what form of heart rhythm she had and whether there was any evidence of other problems. The chest X-ray was to determine whether there was any sign of esophageal problems. At this point in his medical examination, Dr. Whyte strongly suspected Heather Brenan needed to be admitted.

[29] When the test results came back a few hours later, Dr. Whyte confirmed the results showed Heather Brenan was in acute renal failure, probably because of inadequate oral intact, which he thought was due to an esophageal or stomach problem.

[30] Dr. Whyte made the decision to admit Heather Brenan. The reasons for admission were the ongoing need for IV fluids, the need for frequent assessment of vital signs, and a need for consults and investigations that cannot be done as an outpatient. He said specialty tests require in-patient preparation and administration.

[31] Dr. Whyte, along with Sandy Schreider, reviewed the medications Heather Brenan was on when she entered the hospital. A decision was made to discontinue a number of medications and to continue others. Some of the medications were discontinued because they could be harmful to somebody in renal failure. Of relevance was the Pradaxa, the blood thinner Heather Brenan took for atrial fibrillation to prevent a stroke. According to Dr. Whyte, Pradaxa is not to be used by people who have renal failure. It is also not recommended for people undergoing certain tests, such as biopsies, as it can increase the risk of bleeding during such a procedure.

[32] Dr. Whyte's expectation was Heather Brenan would be admitted to a ward and would then be under the care of a family physician who would have continuous care of Heather Brenan.

[33] Dr. Whyte testified Heather Brenan was placed on oxygen on January 24, which she used intermittently. The reason she was put on oxygen was because her oxygen level had decreased slightly when they were giving her the fluid boluses in the ED to address her dehydration. Dr. Whyte said a normal oxygen saturation level for a person of Heather Brenan's age would be above 94%. He testified that the saturation monitoring process is often abnormal in patients who are dehydrated, because they do not have enough perfusion to their peripheries to provide an accurate result. Therefore, she would have been put on extra oxygen on the assumption that she may be low on oxygen but they did not know definitively she was in fact low on oxygen.

[34] Dr. Whyte explained Heather Brenan was not immediately admitted to a ward under the care of a Family Physician because the hospital was in an overflow position; that is, SOGH needed to admit more patients than it had beds for.

[35] Dr. Whyte confirmed his acute main reason for admission was the mediastinal concern in her esophagus, which was causing her dehydration and the acute renal insufficiency.

[36] He confirmed a diagnosis of esophagitis was made later in Heather Brenan's treatment and was entered in her chart by someone other than him or Sandy Schreider.

[37] Dr. Whyte was questioned as to whether he considered performing a number of tests to determine the cause of the esophagitis and whether he would address Heather Brenan's other issues, such as the weight loss, her not being able to tolerate food and the dysphasia. Dr. Whyte was clear in his evidence his focus at this time was on the acute issues set out above. Those were the reasons she required the hospital stay. Dr. Whyte said when he was treating her, it was too soon to address the issue of dysphasia and stated this was a symptom resulting from dehydration and developing acute renal failure. With respect to her weight loss, and to the question of whether he considered a feeding tube, he said this was not a treatment he would consider as an ED treatment. He would not have been comfortable inserting a tube through Heather Brenan's esophagus due to the esophagitis.

[38] Dr. Whyte was also questioned as to whether Heather Brenan should have been on a blood thinner. He testified that the use of a blood thinner, such as Heparin, would have been a concern at this point in her treatment because the cause of esophagitis was unknown. It could, in certain circumstances, cause an upper Gastro Intestinal ("GI") bleed and overall, he felt the risks of anticoagulation outweighed the benefits. He advised the blood thinner she was previously on - Pradaxa - was not appropriate to continue, given her renal failure. If she was placed under the care of a Family Doctor, he would have had this conversation with the Family Doctor who would have considered the appropriate course of treatment from there.

[39] Dr. Whyte said Heather Brenan was placed on an NPO diet (not per oral diet), because it was not yet understood what was going on with her esophagus and he did not want her consuming anything other than sips of water.

[40] Dr. Whyte was questioned as to whether he saw any symptoms of deep vein thrombosis. He said he did not.

[41] Claudine Knockaert is a registered nurse and has been employed at the SOGH since 2008. She is both a Bedside Nurse and is qualified to be a Charge

Nurse. On January 24, 2012, she was one of the nurses assigned to Heather Brenan. She is not clear if she was the Bedside or Charge Nurse on this day. She testified after Heather Brenan returned from X-ray, she took her vital signs, including her oxygen saturation levels. At 4:10 p.m., her level was 95% on room air. She recalls Heather Brenan indicating she was tired and relieved she was in hospital and receiving treatment. At 6:50 p.m., her oxygen saturation level was 88% on room air; no shortness of breath was reported and no respiratory distress was noted. At 7:40 p.m., Heather Brenan was put on 3 liters of oxygen per nasal prongs. At that time, her oxygen saturation level was between 89-93. This increased to 97% with the oxygen treatment.

[42] Ms. Knockaert administered the IV bolus treatment ordered because of Heather Brenan's dehydration. She made Dr. Whyte aware of this.

1. January 25, 2012

[43] Dr. Mark Schneider is an Emergency Physician at SOGH. He completed medical school in Saskatoon in 2007 and was then accepted into the Family Medicine Program at University of British Columbia. Dr. Schneider was accepted into the Emergency Medicine Program at the University of Manitoba where he completed one year competency training and received his CCFPEM designation, which is an Emergency Medicine Designation in Canada. As of 2010, he was a full time Emergency Physician at SOGH.

[44] Dr. Schneider's shift on January 25, 2012 was 7:00 a.m. - 5 p.m.; he would have been the only Emergency Physician on shift between 7:00 a.m. and 10:00 a.m. There was a Physician's Assistant on shift on January 25th. Dr. Schneider said he made no entries in Heather Brenan's Integrated Progress Notes during any of his shifts. He stated this is not his usual practice, particularly if there is a consultation with a specialist or a change in the management of a patient's care.

[45] Dr. Schneider recalls taking report from Dr. Hardy, who would have worked the night shift. He testified he would have a report on all patients in the ED and he assumed management of all patients as the sole physician on shift at that time. The information would have included what a patient came in with; pertinent details of his/her history; investigations that were done; and most importantly, the plan forward. In Heather Brenan's case, he testified that she came in complaining of dysphasia or difficulty swallowing, and the preliminary

investigations from the day before, including the chest X-ray, indicated a medicinal mass in the centre of her chest. A CT scan had been ordered to investigate that further. He testified Heather Brenan's second issue was an acute kidney injury, evidenced by severe dehydration. He stated Nephrology had been consulted, an ultrasound ordered, and she was being treated with fluids.

[46] Although he did not have specific recollection of reviewing Heather Brenan's chart, he testified he would have reviewed it, as it is his practice to review all vital signs, the chart nursing notes, as well as talking to and examining the patient. He does specifically recall examining Heather Brenan. She described her swallowing and weight loss issues to him, as well as her status with Dr. Mikflicker. He said he did not examine Heather Brenan until the end of the day because of the volume and acuity of the other cases and he was waiting for test results. He reviewed the CT scan results that confirmed a hiatus hernia contributing to the dysphasia. The renal ultrasound indicated some degree of chronic renal failure, but importantly he noted there had been an improvement to her kidneys with the intake of fluids. At this point, he confirmed there was nothing definitive they could see that was causing the dysphasia.

[47] Dr. Schneider ordered her to see Physiotherapy ("PT") and Occupational Therapy ("OT"), as well as the Speech-Language Pathologist. The purpose of the Speech-Language Pathologist was to address the fact that she was having difficulty eating. The Speech-Language Pathologist can recommend a particular consistency of diet to make eating tolerable. Dr. Schneider also ordered Heather Brenan be started on Glucerna, a nutritional drink. The OT/PT assessments were to address the fact she had become quite weak and he wanted to quantify how weak she was and what supports she may need. Specifically, he wanted OT to give a potential recommendation for canes or walkers and home modifications - or Home Care going forward.

[48] Dr. Schneider explained that OT/PT consults help them with the discharge plan. He described three potential scenarios for Heather Brenan: first, she has medical issues and is very weak, so she would continue as an admitted patient; second, she is medically stable but too weak to go home, so she may be a candidate for a Geri-Rehab Unit; or third, she passes OT/PT and although weak, is doing well enough so that if the medical issue is resolved she can be discharged. Dr. Schneider said, although it was a little early in the process to consult with these specialties, it does help inform the plan going forward.

[49] Dr. Schneider reviewed a number of test results for the Court. The result of the EKG indicated atrial fibrillation, which Heather Brenan had prior to entering

the hospital and is the reason she was taking Pradaxa. One of the more relevant results was her blood work, which showed her platelet count was low. He testified that having low platelets reduces a patient's ability to clot blood and this can become a cause of bleeding. This had implications for using any type of blood thinner, as it increases the risk of an upper GI bleed in the stomach or the esophagus. He testified anyone who reviewed the results would conclude anticoagulants were contra indicated.

[50] Dr. Schneider also reviewed the results of Heather Brenan's chemistry panel, including her creatinine level, which indicated her kidneys were struggling. The numbers had improved between the 24th and 25th, but were still high and so the bolus fluid was continued.

[51] Dr. Schneider reviewed the Integrated Progress Notes, over the course of January 25-26, for the Court. He stated her blood pressure was stable throughout her stay; her heart rate was a bit tachycardia, but was normal by the last day she was there. Her respiratory rate was never elevated, either on or off oxygen, and although she required oxygen at times, she was receiving 1-3 litres, which he said is a low flow of oxygen. Her white and red blood count was a bit low, but did not plummet, and her creatinine steadily improved over the three or four days she was in hospital.

[52] He said her oxygen levels could be affected by the fact she was receiving fluid for her kidneys. He testified that, as Heather Brenan died of a pulmonary embolism ("PE"), this could also have caused her oxygen saturation levels to go down, but he said there are many other potential causes for this as well. He said by the end of his shift, Heather Brenan was on a maintenance level of fluid for her kidney function.

[53] When his shift ended at 5 p.m., he gave a report to the incoming doctor, which would have included the results from the tests that day, an update on her kidney function, the fact she was stable, who had seen her, who had yet to see her and the plan forward.

[54] Courtney Maley is a Registered Nurse and graduated from Brandon University in 2010. She has worked in Brandon and at SOGH. She is currently an Intensive Care Nurse at St. Boniface Hospital and takes casual shifts at SOGH.

[55] On January 25, 2012, Ms. Maley worked the 7:30 a.m. - 3:30 p.m. shift at SOGH and was Heather Brenan's Bedside Nurse. She would have had a report from the outgoing nurse, which would normally include the patient's presenting

complaints and any pertinent lab results or diagnostic results. She said she would have reviewed the chart to get any additional information and then assessed the patient.

[56] On three separate occasions, she attended to Heather Brenan. She checked her vital signs, gave her medication, and made her comfortable in bed. She recalls no complaints from Heather Brenan, other than a cough and specifically, no complaints of shortness of breath. Heather Brenan denied any difficulty swallowing. She recalls Heather Brenan going for an ultrasound. Her independent recollection was that Heather Brenan was a very nice lady who was chatting with her. She recalls she spoke on the phone to her daughter. Her friend, Ms. Northage, was visiting with her. She said Heather Brenan denied being in any pain and she was on oxygen the entire time Ms. Maley looked after her. She does not recall seeing her up out of bed. She does recall Heather Brenan was waiting for a bed on a ward and she testified that it was very busy at that time of year with more people coming into the ED than leaving.

2. January 26, 2012

[57] Dr. Neil Swirsky was the ED doctor who changed Heather Brenan's status from admitted to a "hold". Dr. Swirsky graduated from the University of Manitoba with a Medical Degree in 1975, and completed a one-year internship in 1976. He started practice at the St. Boniface Emergency Department in July 1976 and in 1982, he successfully challenged the specialty exams in Emergency Medicine offered by the Royal College of Physicians and Surgeons. Also in 1982, he became Head of Emergency at St. Boniface Hospital and held that position until 1993 when he became Chief Medical Officer at SOGH. He remained in that position until 1994. From 1994 until sometime after January 2012, he worked full time as an Emergency Physician at SOGH.

[58] On January 26, 2012, as the 7 a.m. Physician, he assumed care of the patients already in the department, including Heather Brenan. He would have taken a report from the outgoing Physician, including a report on Heather Brenan. His recollection was he was aware of the tests that had been performed, her kidney failure, her difficulty swallowing, the abnormal chest X-ray, the CT scan, and the renal ultrasound. He also knew about her weight loss. In addition, he knew what tests she was waiting for and what the next steps were. By the time he assessed Heather Brenan, he was aware the CT scan confirmed a hiatus hernia, which had been diagnosed by Dr. Mikflicker after Heather Brenan's gastroscopy on

January 2. He believed the hiatus hernia with the esophagitis was the cause of Heather Brenan's swallowing difficulties.

[59] Heather Brenan, while at SOGH ED, was placed in "Pod 3". Dr. Swirsky provided a helpful explanation of where that is within the ED. He said there are four areas in the department: the first area is minor treatment, which is located in a separate hallway; the second area is located in the "middle section" around the main desk, which is used for not quite minor treatment but not quite really sick; the third area is the acute section, which has two Pods, and monitors beds for the sickest patients; the fourth area is Pod 3, which are not monitored beds and are for patients who are more stable and waiting to go to a ward. It is used as an overflow area and is not open at all times.

[60] At the time he saw Heather Brenan, he was aware one of the reasons she had been hospitalized was because of severe dehydration. He knew she had been assessed by Nephrology - the kidney specialty service - and she had an ultrasound of her kidneys. He said that her kidney function had improved significantly. As a result, he reduced the intravenous fluid she had been receiving. He ordered Glucerna, a nutritional beverage to address her lack of nutrition. He ordered medicine to address the hiatus hernia and her swallowing difficulties. He further followed up with OT/PT and asked that they see her as soon as possible, as those orders had been placed the day before.

[61] In Dr. Swirsky's opinion, the CT scan confirmed that she had a hiatus hernia and not something more serious; her dehydration and renal failure issues were largely resolved and this was confirmed with various tests. In his view, the remaining outstanding issues to be addressed were her weakness and her swallowing issue, as this had led to her weight loss. He thought, if the swallowing issue could be addressed by a repeat gastroscopy and she was functionally fit; she could be discharged.

[62] Dr. Swirsky arranged for the gastroscopy Heather Brenan was supposed to have on February 2, to be brought forward to the next day, January 27. He also arranged for a Neurologist to see Heather Brenan to see if there was anything else causing the swallowing difficulty.

[63] With respect to Heather Brenan's mobility, Dr. Swirsky said he had not seen her up and around but believes the nurses had seen her mobile when she went to the bathroom. He was waiting on the Functional Assessments of OT/PT to address her functionality. He believed he ordered her oxygen supplement to be reduced to one litre to see how she would manage on the reduced dosage. The

documented oxygen saturation levels indicated she remained within normal levels on one litre of oxygen.

[64] Based on his review and pending the outstanding assessments, including the gastroscopy to be performed by Dr. Micflickier the next day, Dr. Swirsky felt there was the potential Heather Brenan could be discharged. As a result, he changed her status from an "admitted" patient to a "hold", meaning she was no longer eligible to be admitted to a ward.

[65] Dr. Swirsky explained this decision. He felt given the number of patients waiting for beds at that time, far more than he would have liked to see, and given his duty to try to keep patients moving to a disposition, holding Heather Brenan in ED, rather that admitting her to a bed in a ward, was appropriate. If she had the gastroscopy the next day and it revealed some reason she should be admitted, she could be changed back to an admitted status.

[66] Likewise, he said if the OT/PT or swallowing assessment indicated a reason to admit her, her status would have been changed back. Dr. Swirsky said he did not advise Heather Brenan as to the change in her status.

[67] Dr. Swirsky was questioned as to whether he saw any symptoms of deep vein thrombosis ("DVT") or PE, in Heather Brenan. He said he did not.

[68] Dr. Swirsky was also questioned on whether it would be appropriate to give anticoagulants to Heather Brenan. He said he was aware she was on Pradaxa in the community for her arterial fibrillation and he was aware this had been stopped because of the impairment of renal function. He is aware Heparin is another alternative as an anticoagulant. However, because Dr. Micflickier would likely perform a biopsy during the gastroscopy, and because of the risk of bleeding during that procedure, he did not consider it appropriate to order Heparin. He also said that although Heparin, if given intravenously, could be shut off prior to the gastroscopy, he would remain concerned because there could have been lingering effects from the Pradaxa. The combination of two anticoagulants in Heather Brenan's system could have increased the risk of bleeding complications.

[69] Dr. Swirsky was also questioned on what other treatments could be considered for hiatus hernia, as well as alternatives to a gastroscopy. Dr. Swirsky said those were matters to discuss with a specialist. As Heather Brenan had Dr. Micflickier as a specialist and as she was to see him the next day, he would defer those decisions to him.

[70] Dr. Swirsky finished his shift at 5:00 p.m. He said he would have given his report to the doctor taking over. He testified that although the OT/PT and swallowing assessments were completed on January 26, he did not see the results before he finished his shift. He did work on January 27, but he started at 10 a.m. New patients who arrive in Emergency are seen by the 10 a.m. Physician and not the existing patients, therefore he would not have seen Heather Brenan on January 27.

[71] Dr. Swirsky handed off to Dr. Schneider. Dr. Mark Schneider began his shift at 5 p.m. on January 26. He was also Heather Brenan's doctor on January 25 for the 7 a.m. - 5 p.m. shift. Dr. Schneider says on January 26, he does not specifically recall the handover from Dr. Swirsky.

[72] In reviewing the medical notes, he testified he had the Nephrology Report indicating there was no neurologic disease responsible for the dysphasia; he also believes he would have known that Heather Brenan was continuing to improve and that an endoscopy had been arranged for the next day. He would have reviewed the vital signs and notes to see if there were any issues and he said he might have talked to the patient. He said he may have seen Heather Brenan that day but he does not recall. He said that it is possible, if she were stable, he would not have seen her. The plan was to wait to have the endoscopy the next day and to go from there.

[73] Dr. Schneider handed off to the oncoming doctor at 2 a.m. He does not recall exactly what he would have reported to the oncoming doctor, but assumes it was similar to the information he had received when he came on shift at 5 p.m. Dr. Schneider made no notes regarding Heather Brenan on January 26.

[74] Dr. Schneider worked the 10 p.m. - 7 a.m. shift on January 27. He did not have care of Heather Brenan during that shift. He did however, have contact with Dr. Paul Dowhanik when Heather Brenan returned shortly after midnight on January 28. Dr. Schneider remembers the "red uniform nine" code that indicated someone was coming in who needed resuscitation. He went to the resuscitation room and Dr. Dowhanik came in behind him. Dr. Dowhanik said he knew the patient and said he would take her. Dr. Schneider then left the room and carried on with his other patients. He spoke to Dr. Dowhanik after the resuscitation and they reviewed the case. Dr. Schneider said it is not uncommon for colleagues to do this in this situation to consider what had happened. They were considering whether Heather Brenan might have had a cardiac arrest. Dr. Schneider did not, at that time, consider a PE as a cause, since she did not have symptoms consistent with a PE.

[75] That was the end of Dr. Schneider's involvement. Dr. Schneider made no notes regarding Heather Brenan on January 27 or 28.

[76] Ali Collins is an Occupational Therapist. She examined Heather Brenan on January 26, as per the doctor orders made January 25. Ms. Collins has a Bachelor of Science with a major in Chemistry, which she obtained in 2008, and Masters Degree in Occupational Therapy, obtained in 2010. She has worked with the Parkland Regional Health Authority and the Winnipeg Regional Health Authority. She was employed full time at SOGH in January 2012. Her hours at SOGH were 9 a.m. - 5 p.m., Monday through Friday.

[77] As an OT, Ms. Collins works in Emergency, ICU and Surgery. She works primarily in Discharge Planning, where she assesses patient's functionality prior to and at the time of discharge, to determine if they can function independently in the community. The goal is to ensure a patient is at his/her baseline functionality prior to discharge; OT ensures the patient can get dressed, get up and around, get to the bathroom in the same way he/she was able to prior to being admitted to the hospital. As an example of baseline, if a person used a cane prior to being admitted, OT would expect he/she could manage their activities using a cane when discharged.

[78] Ms. Collins' practice is to review the chart, find out the past medical history, diagnosis, talk to the nursing staff about the patients mobility, find out what their living and family situation is and speak to the patient directly. She testified, OT usually works closely with PT and they conduct their assessments together, so as to not duplicate questions and assessments with the patient. In this case, she did work with Deb Prideaux, the Physiotherapist.

[79] With respect to Heather Brenan, she noted she was in her bed in Pod 3, she was on 3 litres of oxygen per nasal prongs, and she had a Foley catheter and an IV. Heather Brenan told her why she had come to the hospital and although it was evident Heather Brenan was frustrated with her inability to swallow; Ms. Collins said Heather Brenan was very nice, friendly and cooperative. She was also an excellent historian.

[80] Prior to admission, Heather Brenan advised OT/PT she lived in a bungalow and she had to manage the stairs in and out of her house; she was able to go to the basement; she used a cane or a walker; and she was able to transfer from one surface to another. In other words, Heather Brenan was able to get up from a bed or couch. She managed her toileting fine and she used a wall bar to get up and down from the toilet. She was able to shower independently and she was

independent to shop, get medications and prepare meals. Heather Brenan reported that while she had some trouble getting to her basement to do laundry, she still managed. She said she still drove her car but had not done so since she became weaker. Heather Brenan said she had not fallen, but was afraid of falling. When speaking of her activity tolerance, Heather Brenan said it was not as good as usual because she had not been eating.

[81] Ms. Collins' assessment of Heather Brenan's status on January 26 was based on the self-report: watching her dress, mobilizing her and walking her to the bathroom in the ED. Ms. Collins noted Heather Brenan used a walker to get to and from the bathroom and she was able to perform the necessary toilet function using the bathroom bars for support. Ms. Collins said Heather Brenan took the oxygen with her when she walked to the bathroom.

[82] Ms. Collins found Heather Brenan to be functionally independent. In her view, she could be discharged when she was medically stable, which meant when she was ready to have the oxygen, the IV and the Foley catheter removed. Ms. Collins noted Heather Brenan's activity level was lower than when she entered the hospital and she noted she got short of breath quickly. However, notwithstanding this, it was her view that Heather Brenan was able to do everything that needed to be done before she left the hospital. She agreed the shortness of breath was an issue, but she said it was a medical issue to be resolved. Short of a change in her condition, she did not feel the need to see her again, although she did indicate she would have done a reassessment once her shortness of breath had improved, if such a consultation was requested.

[83] Ms. Collins would have passed this note onto the nursing staff and left her paperwork reflecting the assessment in the ED on the chart.

[84] Deb Prideaux also assessed Heather Brenan on January 26. Ms. Prideaux is a PT and she received her diploma from the University of Manitoba in 1975. She has worked at various places in Manitoba, as well as British Columbia. After taking time off to raise her children from 1981 - 1986, she took a re-entry program in 1986. She worked full time at SOGH in the Emergency, ICU and Surgical departments from 1986 to March 2012. Her hours were Monday to Friday, 8:00 a.m. - 4:15 p.m. She is the only PT for those departments.

[85] Ms. Prideaux's practice is similar to Ms. Collins, in that she reviews the chart, gets a medical history, gains an understanding of why the patient is in the hospital and reads the diagnosis. She also interviews the patient. She assessed Heather Brenan with Ms. Collins. Ms. Prideaux said OT/PT testing takes

approximately one hour. Her focus is to see how well Heather Brenan moves in terms of range of motion: sitting, standing and walking. The doctor's order she received said Heather Brenan had difficulty mobilizing and transferring prior to admission. It requested PT assess her for a walking aide.

[86] Ms. Prideaux had Heather Brenan perform a series of tests: moving her arms and legs, resistance tests to assess her strength, and getting off her bed. She would have started the tests with Heather Brenan laying on the bed and then moving her to a standing position. Her assessment showed Heather Brenan had average strength and her range of motion was functional. It also showed she was able to walk independently (without a person assisting) to the washroom near Pod 3, approximately 25 feet away, with the use of a walker. Like Ms. Collins, she felt she was functional in her use of the bathroom. She noted Heather Brenan moved independently around her bed without the assistance of a walker. Ms. Prideaux did note Heather Brenan became mildly short of breath walking to the bathroom and she advised she would not have wanted to see Heather Brenan walking to the bathroom without the oxygen because of her shortness of breath. Similar to Ms. Collins, she felt the use of oxygen was a medical issue that had to be addressed before Heather Brenan went home, but it was not her issue to address.

[87] Her final assessment of Heather Brenan was at her baseline of mobility and she noticed her exercise tolerance was decreased. Ms. Prideaux was concerned about Heather Brenan being on oxygen when doing the tests; she should have been able to walk further without tiring as quickly. Ms. Prideaux testified that she did not feel the need to see Heather Brenan again. In her view, despite decreased mobility building up over a few months, she was able to move, to walk using a cane or walker and she was able to get up and down stairs safely. She did however; say she would have liked to see Heather Brenan before discharge, to see how well she managed without the Foley catheter, IV and oxygen.

[88] Valerie Hachey, a Registered Speech-Language Pathologist with the College of Audiologists and Speech-Language Pathologists of Manitoba, also examined Heather Brenan on the afternoon of January 26, 2012. Ms. Hachey has advanced competencies in dysphasia, or swallowing disorders, and has been working as a Speech-Language Pathologist since 1980. She has been working at SOGH since 1989 and has worked in the field of dysphasia since 2000.

[89] Ms. Hachey advised there are two main branches to Speech-Language Pathology; communication and dysphasia. In this case, she was consulted regarding Heather Brenan's dysphasia and her main concern was to ensure she had a safe swallow for oral intake. Ms. Hachey explained there are three phases to

swallowing. In simple terms, the first stage is the oral stage where the Speech-Language Pathologist ensures a patient has the muscle movement and control to move food around the mouth, chew and propel the food to the back of the mouth to trigger the swallow reflex. The second stage is the pharyngeal stage, which ensures the food goes down the correct tube, namely the esophagus to the stomach and not the trachea, which would take the food into the bronchial tubes and lungs, which could cause an aspiration. The third stage is the esophageal stage, where food goes down the esophagus and into the stomach. Ms. Hachey can assess the first two stages at bedside, but not the third stage. A Speech-Language Pathologist can identify symptoms of dysphasia at the first two stages, but they cannot diagnose dysphasia at bedside in the third stage. The third stage is the transition between speech pathology and medicine.

[90] Ms. Hachey's primary role is to look at the pharyngeal stage of swallowing. The objective is to determine if it is safe to order a diet and if so, what type of diet consistency would be appropriate. Diet consistency refers to the thickness of the fluids. So depending on a patient's assessment, he/she may tolerate a thin or a denser fluid diet. A denser fluid diet is based on the viscosity of the food.

[91] In Heather Brenan's case, the presenting complaints were difficulty chewing and food getting stuck in her esophagus. Ms. Hachey believes she was aware Heather Brenan was having a gastroscopy the next day. She obtained a history from Heather Brenan and she began her assessment. She determined from Heather Brenan that she could not tolerate solids and therefore she did not test her on solid food. She did test her with thin fluid - water - and saw she did not have any problems at the swallowing or the pharyngeal stages. She found Heather Brenan could tolerate thin liquids without issue. She determined Heather Brenan's swallowing problems were at the esophageal stage and this needed to be assessed medically.

[92] Ms. Hachey recommended a diet consisting of meat, potatoes and vegetables, which are blended into a thin liquefied consistency. Ms. Hachey said this diet could include an Ensure type supplement; however, she was clear it is not her role to determine what specific foods are taken in, her role is to recommend a consistency in diet so that the patient can properly swallow the food.

[93] Ms. Hachey's plan was to follow up with Heather Brenan either as an in-patient or an out-patient, depending on the results of the gastroscopy. She testified it is a medical decision as to whether Heather Brenan would have been reassessed by her at a later date. Given that Heather Brenan was on a 'nothing per

oral' or NPO because of the upcoming gastroscopy, Ms. Hachney knew she could not follow up until the following Monday (since she works Monday to Friday).

[94] Ms. Hachey placed the results of her assessment on the chart. If Heather Brenan had remained in hospital, and depending on the results of the gastroscopy, a clinical Dietician may have become involved to educate her on how to make the blenderized diet that was recommended. Ms. Hachey would have expected the nurses to monitor Heather Brenan's intake of the blenderized diet, or if she was discharged, to advise her how to obtain a supplement like Ensure.

[95] Ms. Hachey did call Heather Brenan's home several weeks later to follow up, not realizing she had passed away. Her intention was to determine how the gastroscopy had gone and see if Heather Brenan required follow up. She spoke with Dana Brenan and was advised Heather Brenan had passed away.

[96] Martha Hyrnuik, a social worker, also saw Heather Brenan on January 26, 2012. She has been a social worker since 1974 and she obtained an Advanced Social Work Practice specialization in Health Care in 1983, an Advance Gerontoly Certificate from the University of Manitoba in 1991, as well as certificates in Marriage and Family Therapy Theory and a Masters in Marriage and Family Therapy. She has worked at SOGH since 1989.

[97] Her primary role in the hospital is to determine if a patient can return to his/her previous living situation. She focuses on physiological factors, such as support outside the hospital from family and friends, and any problems or barriers identified which would impact the patient in terms of returning to his/her previous living situation.

[98] She offered her assistance to Heather Brenan when she saw her in bed three of Pod 3 in the ED. She visited Heather Brenan on her own account and not because a request to consult was given by a doctor. Ms. Hryniuk indicated this is not an unusual practice, since she tries to assist where necessary. She acknowledged her consultation is with a view to assist the patient on discharge and this planning starts as soon as the patient enters the hospital.

[99] Ms. Hrynuik reviewed the chart and had a discussion with Heather Brenan. When she met Heather Brenan, Ms. Northage was with her. In her discussion, Ms. Hryniuk referred to Heather Brenan as "Mrs. Brenan" and she felt this approach clearly offended Heather Brenan, as she perceived her to be fiercely independent.

[100] Ms. Hrynuik asked a series of questions and from that she understood Heather Brenan's living situation and medical issues prior to arriving in hospital, including her ability to manage and function at home. Specifically, she understood Heather Brenan was fatigued, could not do her laundry and had difficulty with meal preparation because both her laundry and freezer were in the basement. Heather Brenan communicated her concern that she would not be able to function at home and hoped, if she did not remain in hospital, she would have some assistance from Home Care to help her with showering at home, medications and house cleaning. During their conversation, Ms. Hrynuik noted Heather Brenan to be coughing and short of breath. She did not complete the assessment once she realized Heather Brenan was scheduled for gastroscopy the next day but she did recommend to the nurses that OT/PT and Home Care stop by to see Heather Brenan.

[101] Ms. Hrynuik was shown the OT/PT assessments during her testimony and she acknowledged there were inconsistencies in what Heather Brenan had told her about her abilities to manage at home versus what she told the PT. Given this, Ms. Hrynuik said that, had she remained involved and once the medical issues were resolved, she would have met with OT/PT and they would have discussed Heather Brenan's case, resolved any inconsistencies and determined what if anything, she needed to assist her once she got home.

[102] Ms. Hrynuik referred to these meetings as "team huddles" and she said they often take place between these health care providers. They discuss a particular case in order to find the best way going forward to address any outstanding issues. There was no team huddle between herself and OT/PT in Heather Brenan's case.

[103] Ms. Hrynuik said she was contacted on the weekend about Heather Brenan's death. She called the home number listed on Heather Brenan's admission form and spoke to Dana Brenan. She said she wanted to be sure she was speaking to a family member because Heather Brenan left her with the impression she had no family. Dana Brenan was obviously upset being questioned about her family relationship to Heather Brenan and the call did not go well.

[104] Ms. Northage testified she was present when Ms. Hrynuik saw Heather Brenan. Her evidence was Ms. Hrynuik approached Heather Brenan, introduced herself and advised Heather Brenan she was either going to be sent home or she would be put in a nursing home. Ms. Northage then testified Ms. Hryniuk ultimately said Heather Brenan would be sent home and Home Care would definitely be arranged to assist her. Ms. Hryniuk denies she ever said

anything about a nursing home to Heather Brenan. The Court finds Ms. Northage may have misunderstood the conversation between Heather Brenan and Ms. Hrynuik. This may have been due to her overwhelming concern that Heather Brenan was weak and had not eaten and she wanted to see that her friend had the supports that she needed. However, there is no other reference in the evidence to a care home being considered at any point in time. The Court finds it more likely Ms. Hryniuk discussed a Home Care consult with Heather Brenan, since that is consistent with Ms. Hrynuik's oral evidence and her actions.

[105] Evelyn Hillary is the hospital based Case Coordinator for Home Care. She also assessed Heather Brenan on January 26, 2012. Ms. Hillary obtained a Registered Nursing Certificate in 1989 and her Bachelor of Nursing in 1993. She has worked as a nurse for 15 years and for the last 10 years, she has worked for Home Care. She was in a part time permanent position at SOGH in January 2012. Her hours are Monday to Friday, 8:30 - 4:40 p.m., two - three days a week. She worked primarily in the ED department. She would have been the only Home Care Provider in the ED at that time. There was no Home Care Coordinator available on the weekends in January 2012.

[106] Ms. Hillary testified Home Care is a community-based service. In the hospitals, their role is to assess patients and determine if there is any Home Care services needed on discharge. She would begin by reviewing the patient chart and understanding his/her medical issues, history, diagnosis, functional status and course of hospitalization. Home Care then consults with other Allied Health professionals, such as OT/PT and nurses, to determine the patient's status and needs. Home Care also interviews the patient, as well as any family who is available. Home Care looks at both the patient's medical needs (for example dressing changes, injections etc.) and functional needs.

[107] Home Care keeps an electronic chart of their assessments, which can be accessed around the city by all Home Care personnel that need it. This electronic chart is not available to the hospital. The discharge plan is contained in the electronic chart and is used in the community after discharge.

[108] Ms. Hillary believes she was contacted for a consult by Bed Utilization, whose role, as she understood it, is to keep patients moving forward through the hospital. She recalls reviewing Heather Brenan's chart and having a brief discussion with her. She observed Heather Brenan to be on oxygen, an IV and she had a Foley catheter. She said she was sitting in a chair and did not appear to be particularly mobile. Her recollection is Heather Brenan's primary concern was to have help with housekeeping, etc. Ms. Hillary made a note that she would see

Heather Brenan on discharge. She noted that Foley care should be taught, if it was still needed, and if Heather Brenan was to be discharged with oxygen, an additional consult with respiratory would be needed. In her view, given the oxygen, Foley and IV, Heather Brenan was not ready for discharge when she saw her and she felt she was not in a position to assess Heather Brenan's needs at home. Ms. Hillary said that usually, once the patient is ready to go home, the nurses would call Home Care and a plan would be finalized.

[109] Ms. Hillary explained if a patient needed essential services, such as oxygen, toileting, injections etc., from Home Care, and if these services could not be arranged immediately, the patient would remain on a hospital "hold" until the services could be arranged. Services such as housekeeping, laundry and some food preparation are not considered to be essential services. In her view, although she noted Heather Brenan to be short of breath when she saw her, she did not feel she needed any essential services.

3. January 27, 2012

[110] On January 27, 2012, Heather Brenan attended at Victoria General Hospital for her gastroscopy with Dr. Allan Micflickier.

[111] Arvadell Egefz was the nurse who accompanied Heather Brenan to the Victoria General Hospital. Ms. Egefz is a Registered Nurse, graduating in 1973. She has worked in that capacity, and specifically at SOGH, from 1981-2005. She retired in 2005 and had a permanent part-time position for some time. On January 27, 2012, she worked in a casual position as an Escort Nurse. She had given up her nursing licence by this time.

[112] Ms. Egefz's role as the Escort Nurse is to have a medical history of the patient, consult with the nurse on duty for a report on the patient, and ensure the patient is comfortable and medically stable before the patient is transferred to the other hospital. The Escort Nurse takes only part of the medical chart to the receiving hospital.

[113] Ms. Egefz assessed Heather Brenan before leaving SOGH. She noted the IV and catheter but said Heather Brenan was not on oxygen at SOGH. She found her in satisfactory condition to transport. She did not include her assessment on Heather Brenan's chart, although she said this is usually done.

[114] At approximately 12:30 p.m., Heather Brenan transferred herself from her bed at SOGH to a stretcher. The drive to Victoria General Hospital was uneventful. She was admitted to the Victoria General Hospital and waited for her procedure.

[115] Dr. Micflickier testified and explained the procedure which Heather Brenan underwent. Dr. Micflickier is a Specialist in Gastroenterology. He graduated from the University of Manitoba in 1971 and did his Internal Medicine Specialty at the University of Manitoba. He attended the University of Minnesota from 1974-1976 and did his Subspecialty in Gastroenterology. He has practiced in Manitoba ever since.

[116] Dr. Micflickier explained the gastroscopy procedure is used on people who have upper GI problems, such as trouble swallowing, regurgitation, and heartburn. The procedure is used both for diagnostic and treatment reasons. A flexible scope with a camera is passed through the mouth that allows him to see the esophagus, the stomach and the duodenum.

[117] Dr. Micflickier performed a gastroscopy on Heather Brenan on January 2, 2012 and reported back to her family physician Dr. Bhayana. At that time, Heather Brenan had presented with difficulty swallowing and retrosternal discomfort. The gastroscopy demonstrated an inflammation of the esophagus but no obstruction. Dr. Micflickier prescribed a double dose of an anti-acid blocker medication because he felt acid reflux was the cause. He planned to do a follow up gastroscopy at a later date.

[118] Dr. Swirsky contacted him and the gastroscopy was brought forward to an earlier date. Dr. Micflickier understood Heather Brenan was having some chest discomfort and trouble swallowing. The purpose of the gastroscopy was to determine if there had been any change to her swallowing status at that time.

[119] During the procedure Heather Brenan was sedated and her oxygen saturation level dropped to 75%. Dr. Micflickier was able to view the esophagus, the stomach and the duodenum, but he removed the scope and did not perform a biopsy. Due to Heather Brenan's drop in oxygen during the procedure, they changed her oxygen supplement from nasal prongs to an oxygen mask to increase her oxygen levels. Her oxygen saturation did come back up to 89-90% before she was transferred back to the surgery centre to recover from the surgery.

[120] The gastroscopy showed ongoing inflammation of the esophagus. There was fluid in the esophagus, probably because of refluxing from her stomach, but

there was no obstruction. In Dr. Micflikier's opinion, her difficulty swallowing was due to the inflammation of her esophagus. His diagnosis was severe esophagitis due to acid reflux. Dr. Micflickier explained he wanted to do a biopsy to see if there was a yeast infection from candida. He felt that this might not be the case as it did not look like it, but he wanted to confirm it. He said the biopsy was not absolutely necessary and his plan was to follow up on that in the future.

[121] With respect to her drop in oxygen saturation, Dr. Micflickier said it could be because of the procedure itself, since the scope causes people to gag and causes the oxygen saturation level to drop. It could also have been because the medication administered. Dr. Micflickier did not think it was the medication because it was a low dose. He said this drop in oxygen saturation was more than he would have expected.

[122] Dr. Micflickier testified he spoke to the Transport Nurse about Heather Brenan's drop in oxygen saturation and he sent her back to SOGH with a number of forms, including a Consultation Record. The Consultation Record contained his note which said:

> Increased fluid in esophagus with exudates; not biopsied as had trouble tolerating the procedure; stomach, duodenum unremarkable; (lists medications and amounts); I could not do biopsy as she was having difficulty tolerating endoscopy

[123] Dr. Micflickier explained that he purposefully filled out the Consultation Sheet and advised the Transfer Nurse to take it back to SOGH because he felt this was the best way to have direct communication with the Emergency Physicians at SOGH. He said it is not his practice to telephone, since it is very difficult to get a hold of the doctors in the ED. He assessed Heather Brenan prior to her leaving the Victoria General Hospital and considered her to be stable enough to transport.

[124] In addition to the Consultation Sheet, Dr. Micflickier also dictated a report the same day and requested it be typed and sent to SOGH on a rush basis. The report included a statement which communicated he was prepared to do another gastroscopy and biopsy at another time when her pulmonary status and breathing issues were sorted out. Dr. Micflickier acknowledged he did not make a note in either of these documents mentioning specifically Heather Brenan's oxygen saturation level dropped to 75%. His recollection was it was contained in the Integrated Progress Notes of the Victoria General Hospital that would have gone back to SOGH and he believes he communicated this information to the Transfer Nurse as well.

[125] The typewritten report does not appear to have arrived at SOGH Emergency Room prior to Heather Brenan's discharge.

[126] Dr. Micflickier indicated towards the end of his testimony, the drop in oxygen saturation could have been due in part to the sedation, partly because the tube was inserted, partly due to the chest infiltrate and in retrospect, because there may have been something going on in her lungs at the time, such as a PE. He did say he would not have thought of a PE at the time, but in hindsight it could have been one of the causes.

[127] Dr. Micflickier was questioned as to whether he received a page from Dr. Dowhanik. He said he has his pager with him at all times including on the weekend and he did not receive a page as far as he is aware. If he had missed the page, his beeper would keep beeping until he dealt with the page.

[128] If he had spoken to Dr. Dowhanik, he would have advised him to continue the medication Heather Brenan was on. He would have left the other medical matters to Dr. Dowhanik but he testified he did feel her oxygen saturation issues were an issue.

[129] Dr. Micflickier advised he had a conversation some weeks later with Dana Brenan who told him Heather Brenan had been discharged that night. He said he told Dana Brenan this surprised him, as he thought Heather Brenan had issues that needed to be addressed, including her oxygen saturation levels.

[130] Following the procedure, Ms. Egefz was advised the procedure was not completed because Heather Brenan was having trouble with low oxygen saturation levels. Ms. Egefz was also advised the diagnosis was esophagitis.

[131] After an observation period of approximately 30 minutes, and after Heather Brenan's vital signs are monitored and considered stable, she was transported back to SOGH.

[132] At approximately 7:00 p.m., Ms. Egefz returned to SOGH with Heather Brenan. Documentation brought back from the Victoria General Hospital included: her Admission Report, the Surgical Report the Postoperative Instructions and Orders from Dr. MicFlickier. A typewritten report from Dr. Micflickier was not included in the documents sent back to SOGH.

[133] The Hospital Records from Victoria General Hospital indicate Heather Brenan had her oxygen decreased from 3 litres to 2 litres prior to leaving the hospital. She was awake and comfortable and tolerating water before her

departure. While she slept most of the way back to SOGH, she was alert and talkative when Ms. Egefz left her at SOGH.

[134] Ms. Egefz was asked if she observed any signs of DVT in Heather Brenan when she was in her care. Ms. Egefz said she did not and she would have seen Heather Brenan's legs because she transferred her. She would have expected to see redness and swelling in her legs if there were signs of DVT and she did not observe this.

[135] Ms. Egefz testified she did not see Heather Brenan mobile at all during the time she was with her.

[136] Claudine Knockaert is a Registered Nurse and has been employed at the SOGH since 2008. She is both a Bedside Nurse and is qualified as a Charge Nurse. The Charge Nurse is responsible for flow of the department, dealing with patient concerns, monitoring patient care and communicating with Physicians and Nurses' bedside.

[137] On January 27, 2012, Ms. Knochaert's shift was 7:30 a.m. - 7:45 p.m. From 3:30 p.m. - 7:45 p.m., she was the Charge Nurse. She does not recall where she was as Bedside Nurse prior to 3:30 p.m., but at 3:30 she took report from the outgoing Charge Nurse. This includes information on the patients in the department, admission and discharge status and bed availability.

[138] Ms. Knockaert recalls OT/PT had assessed Heather Brenan. She also knew further investigations were occurring and Heather Brenan had gone for a gastroscopy. Ms. Knockaert was aware, if the results of the gastroscopy were satisfactory, Heather Brenan would be discharged.

[139] Ms. Knockaert testified she was not entirely satisfied with the report she had taken from the outgoing Charge Nurse. She said she would have liked to have had a better report on the reasons Heather Brenan was in the ED, particularly given the length of time she was there.

[140] Ms. Knockaert testified she dealt with the Escort Nurse when she returned with Heather Brenan from Victoria General Hospital and she does not believe she herself had reviewed Heather Brenan's chart. Ms. Knockaert does not recall seeing Heather Brenan during her shift.

[141] Ms. Knockaert did review some of the documents that came back from the Victoria General Hospital. Specifically, she recalls quickly looking through the ones describing the procedure because her shift was ending and she wanted to be

able to report to the oncoming Charge Nurse. What she understood from the documents was there was an issue with Heather Brenan's oxygen saturation level, and as a result of her not being able to lay flat, the procedure was not completed. Ms. Knockaert did not have a better understanding of what the issue was during the procedure because she did not have time to review the documentation thoroughly. Ms. Knockaert does recall the oncoming Pod 3 Bedside Nurse reviewed the Victoria General Hospital documents with her.

[142] The oncoming Charge Nurse was Wayne Didkowski. Ms. Knockaert handed off to him and gave him a report. It is not clear whether she reviewed the Victoria General Hospital notes with him, but she did pass on her understanding of Heather Brenan's status including the possibility of her discharge.

[143] Wayne Didkowski has been a Registered Nurse since 1981. He started working at SOGH Emergency in 1982 and has essentially been there throughout his career. On January 27 his shift was 7:30 p.m. - 7:30 a.m.

[144] What he understood when he started his shift was Heather Brenan had returned from her gastroscopy, at Victoria General Hospital, and it was not an ideal gastroscopy because her oxygen saturation levels dropped during the procedure. The diagnosis was esophagitis and he knew Dr. Mikflikier was going to do a follow up gastroscopy in the community. His information was, although her oxygen levels were low during the gastroscopy, they had recovered and at this point Heather Brenan was a possible discharge, pending medical clearance.

[145] Mr. Didkowski testified that based on the information he had, he approached Dr. Dowhanik, and asked him to reassess Heather Brenan to make sure she was medically clear.

[146] Mr. Didkowski met Heather Brenan when he relieved the Bedside Nurse, Carl Anderson, for his break around 9:30 p.m. By now he had spoken to Dr. Dowhanik a second time and he understood Heather Brenan had been cleared medically for discharge.

[147] Mr. Didkowski discussed discharge with Heather Brenan. He said he would not have reviewed Heather Brenan's chart, as it is not his practice to review the chart of a patient being discharged. In his view, if the doctor has medically cleared the patient after a reassessment, unless there is a concern about something specific, he does not review the chart. He was clear that admission and discharge are medical decisions based on a full set of information known by the attending doctor and he relies on the doctor to make that decision. Further, he said the

bedside nurse would have more information on the patient than he would. Both the Charge Nurse and the Bedside Nurse have the responsibility to raise issues with the doctor. Mr. Didkowski said if he had concerns about Heather Brenan's discharge he would have raised them directly with Dr. Dowhanik. He did not have those concerns in this case.

[148] When Mr. Didkowski spoke to Heather Brenan about her discharge, she said she had two concerns: she did not have her house keys and she did not have a ride home. He told her they would send her home in a taxi and he offered to contact her friend who had her house key to see if the friend could meet her at the house. Mr. Didkowski made a note in the chart that Dr. Dowhanik had reassessed her, and he called Ms. Northage and left a message for her regarding sending Heather Brenan home in a taxi. He requested Ms. Northage meet Heather Brenan at home.

[149] Mr. Didkowski had another discussion with Heather Brenan. He did not chart this conversation. Mr. Didkowski advised Heather Brenan he had left a message for her friend, but if he did not hear back in a reasonable time, by approximately 11:30 p.m., she would not be discharged.

[150] Mr. Didkowski said Heather Brenan was fine with that.

[151] As it turned out, Mr. Didkowski received a call back, not from Ms. Northage, but from Ms. Thompson. He did not realize this was someone other than the person he called and left the message. He explained to Ms. Thompson the plan to get Heather Brenan home in the taxi and said she should meet Heather Brenan at home with the keys.

[152] It was Ms. Thompson's evidence she was not impressed with Heather Brenan being discharged at that time of night with no house keys, and she made that clear in her call with Mr. Didkowski. She contacted Ms. Northage, who coincidentally, was able to take her call, and between them they made arrangements for Ms. Northage to meet Heather Brenan at home.

[153] Mr. Didkowski had a further conversation with Heather Brenan advising he had arranged for a taxi chit and a friend to meet her at home. This conversation was not documented. Mr. Didkowski believes it was because it was so busy in the ED.

[154] He did not actually see Heather Brenan be discharged.

[155] Mr. Didkowski said in all his dealing with Heather Brenan he did not see her up and around. He did see her both sitting in a chair by her bed and in bed.

[156] Mr. Didkowski was again involved in Heather Brenan's case when she was brought back to the ED after she collapsed at home. He heard the code for a cardiac arrest patient being brought in and he attended at the resuscitation room. He spoke with the paramedics who advised they had attempted to resuscitate Heather Brenan and they provided detailed information about the actions they had taken. Mr. Didkowski was the Recording Nurse during the resuscitation. He said the resuscitation was successful and Heather Brenan was transferred to the ICU.

[157] Mr. Didkowski also discussed Heather Brenan's general mobility. It was his evidence that although she may have had some challenges as set out in the report of the social worker, from his perspective, she was mobile - she could ambulate; she could walk, even if it was with someone beside her in case she became unsteady, but she could do so without assistance; she was able to get from her bed to a chair; she was able to get to the bathroom. Those were the types of factors he considered in determining whether she was mobile.

[158] Mr. Didkowski was asked whether he feels pressure to keep patients moving through the ED and he said he did. He said the pressure comes right from the top of the WRHA and filters through all layers of the hospital. He said the goal is to get patients into the ED, treat them and make a plan for their disposition. Mr. Didkowski said the only way to get patients into the ED is to make sure the ones currently in the ED are treated and have a plan for discharge. He said the ED cannot control anything beyond its four walls and, when issues arise regarding length of stay, they work to find solutions; including improving processes to address them.

[159] The Court did not have the impression from Mr. Didkowski that he equates these issues with a lack of patient care; rather he was speaking to the reality of working in a busy ED, where problems do arise occasionally in not having sufficient beds or resources to deal with the number and acuity of patients to be treated.

[160] As of January 27, 2012, there was no formal Safe Discharge Policy at SOGH. This has since changed and a protocol had been put in place, which will be discussed later in this report.

[161] Carl Anderson has been a Registered Nurse since 1991. He has worked in Canada and spent 6 years as a Nurse in the United States. In 1999, he returned to

Canada and spent time working at various hospitals. From 2001 to 2010, he worked full time at SOGH. Since 2010, he has worked full time with Canada Pension Disability, as well as taking casual shifts at SOGH in the ED.

[162] On January 27, 2012, Mr. Anderson worked the 3:30 p.m. - 11:45 p.m. shift at SOGH. He started at 4 p.m., given his full time position with Canada Pension Disability. Mr. Anderson was Heather Brenan's Bedside Nurse in Pod 3 during this time. He worked with a Health Care Aid, also assigned to Pod 3.

[163] Mr. Anderson testified he took report from the outgoing Bedside Nurse and it was very busy in Pod 3 that day. The report includes the patient's age, diagnosis, past history, diagnostics, lab results, X-rays, medications, CT scans and whether anything unusual occurred that day. He said his usual practice is to get a report on all patients in the 6 beds in Pod 3 from the outgoing Bedside Nurse and, while he is getting the report, he visually notes the patient being reported on. Usually, unless one patient is particularly ill, he starts at one end of the Pod and examines each patient. Mr. Anderson testified he does not normally review each chart unless he has questions or something stands out in his mind that needs to be addressed. He relies largely on the information given to him by the outgoing nurse and his own observations.

[164] The outgoing nurse was Colleen Jolicour. She graduated in 1998 as a Registered Nurse. She has worked in various hospitals throughout Manitoba and specifically at SOGH for approximately one year; having taken the SOGH Emergency course. Ms. Jolicour did not testify but was interviewed for these proceedings. She does not recall Heather Brenan or her interaction with her on January 27, 2012. Ms. Jolicour believes the note she made in the Integrated Progress Notes indicates Heather Brenan either told her, or the Escort Nurse told her, Heather Brenan had requested water and was able to swallow it. Beyond that she had nothing to add to the Hearing.

[165] Mr. Anderson testified because it was so busy, he was constantly interrupted with phone calls to have people admitted and he was constantly taking new patients. He believed he moved 3-4 patients up to the wards from the start of his shift to 9 p.m. and then a few more after that time.

[166] Mr. Anderson testified he was on break when Heather Brenan returned from the Victoria General Hospital. He said he received a report on her when he started his shift, with information similar to the above. Mr. Anderson did not speak to the Escort Nurse and he did not see or review any documents from the Victoria General Hospital. Mr. Anderson was aware Heather Brenan was on a

hospital 'hold', she had a gastric issue and she was out for a test at the Victoria General Hospital. When he returned from his break, the nurse who relieved him advised Heather Brenan had returned from her test and there was an issue with her breathing during the test. Mr. Anderson was advised Heather Brenan's breathing was now fine and they were waiting for the doctor to discharge her home. Mr. Anderson understood the nurse who took over for him on break, Colleen Jolicoeur, had assessed Heather Brenan. On reviewing the Integrated Nursing Notes for the Court, Mr. Anderson noted Heather Brenan was on 2 litres of oxygen and her oxygen saturation rate was 95%. He explained that while this is within normal range for someone Heather Brenan's age, he would have liked to see it a bit higher level given she was on oxygen. He explained many factors can affect the oxygen saturation readings. The readings are not a hard and fast test of what the actual oxygen saturation may be.

[167] Mr. Anderson advised he did not assess Heather Brenan himself. However, when he saw her, she did not appear to be distressed. Mr. Anderson saw her sitting in a chair conversing with people and laughing. He did talk to her a few times and noted how she spoke and noted she seemed comfortable overall. Heather Brenan did not appear to be having trouble breathing. He believes he saw her eat or drink something after he had returned from his supper break. He did not chart his observations as he says he does not chart negative findings; that is, if there is nothing unusual, there is nothing to put in the chart.

[168] Mr. Anderson testified Heather Brenan asked to be taken to the bathroom twice and she walked there and back, using a walker, with the Health Care Aid standing by to assist if necessary. Mr. Anderson watched her walk approximately 30 feet to and from the bathroom and had no concerns. Mr. Anderson does not believe she had oxygen when she walked and he said she had no problem ambulating. She held herself up straight. Mr. Anderson said she used her walker 'strongly' but was not leaning over her walker. He testified he did not see her up otherwise and believes she sat in the chair near her bed when she returned.

[169] Mr. Anderson said Dr. Dowhanik was going to reassess Heather Brenan. He saw Dr. Dowhanik reviewing her chart at the desk around 8:30 - 8:45 p.m. He does not recall having a specific conversation with Dr. Dowhanik but he usually will speak with the doctor and the doctor will ask if there is anything to add - meaning has anything unusual happened. In this case, Mr.Anderson does not recall if he had a conversation with Dr. Dowhanik but if he had, he said he would have had nothing to add, because he had no concerns about Heather Brenan at that time.

[170] Mr. Anderson went on his break and Mr. Didkowski covered his patients. Mr. Anderson advised he gave Mr. Didkowski his report - the information he received at hand off - and he would have left him his 'cheat sheet' - the sheet he personally uses when he takes report at the beginning of his shift - on the desk in case anyone needed the information. He said that as Mr. Didkowski was the Charge Nurse, he knew Mr. Didkowski would already have information on Heather Brenan, since he gets reports on all the patients. In these situations, he does not feel the need to pass on every detail he knows about the patient because he will be back in a short while from his break. He did tell Mr. Didkowski, Heather Brenan had been to the bathroom and back; she walked well, looked well and had no complaints or issues.

[171] When Mr. Anderson returned from his break, Mr. Didkowski advised him Heather Brenan would be discharged and Mr. Didkowski had contacted family because they had her house key. Mr. Anderson spoke to two people on the phone about this later that night. The first person - who we now know was Ms. Thompson - was quite upset and was asking why Heather Brenan was being discharged at this time of night. Ms. Thompson said she would have to contact a friend who had the house key. His second conversation was with another person - who we now know was Ms. Northage - who advised she had a key and would meet Heather Brenan at home. Ms. Northage asked to be called when Heather Brenan was in a taxi. Mr. Anderson did call her when Heather Brenan was discharged.

[172] Ms. Thompson testified that she did speak to Heather Brenan on the phone at some point after she had returned from the Victoria General Hospital. She believes it may have been around 10:30 p.m. Heather Brenan advised her that Dr. Mikflicker had to stop the test because she could not breathe. Heather Brenan also advised her she was being sent home in a taxi and she was concerned because she could not reach Ms. Northage and could not remember her cell phone number. She asked Ms. Thompson to call Ms. Northage to advise her she was being sent home and Ms. Thompson did so.

[173] Mr. Anderson testified he spoke to Heather Brenan about her discharge, asked her if she felt safe to go home and he asked her if she had any concerns. Heather Brenan said she had no concerns but would like a sleep aid and could the doctor give her something to tide her over until she could get to a pharmacy. Mr. Anderson arranged that for her.

[174] Mr. Anderson removed Heather Brenan's catheter, spoke to her about her medications and advised her she should come back to ED if she had any issues. He saw the Health Care Aid take her in a wheelchair to where she would get a taxi.

Mr. Anderson's evidence was he had no concerns about Heather Brenan on discharge and he stated there were no functional or medical issues he was aware of when she was sent home.

[175] Mr. Anderson was questioned on whether he saw any signs of DVT. He said he did not. He also said he had a good look at Heather Brenan's legs because she walked to the bathroom and back. Her legs had good colour, there was no redness and she was not limping as though she any had pain in her legs.

[176] Mr. Anderson was not aware of any of the notes from OT/PT or Home Care. He testified that had he been aware, he would have advised Dr. Dowhanik and would have had the issues readdressed. He added that Heather Brenan's condition could have changed from the time she was originally assessed by the Health Care workers, and he would have brought it to the doctor's attention.

[177] Dr. Paul Dowhanik was the ED doctor at SOGH on January 27, 2012. His shift was 5 p.m. - 2:00 a.m. Dr. Dowhanik graduated from Medical School, at the University of Manitoba, in 1991. He has worked in Emergency Medicine for most of his career, both in rural Manitoba and at Misericordia Health Care and SOGH. He also worked in Australia for a year in the field of Emergency Medicine. He worked at SOGH between 1993-1996 and returned to SOGH in 1998 and has been there ever since. In addition to being an ED doctor, he is currently an Assistant Professor of the Department of Medicine at the University of Manitoba.

[178] Dr. Dowhanik testified the ED is a very busy place and he remembers that being the case on January 27, 2012. He took hand off from a Dr. Sokolies (who did not testify) and he said the sign over was typical. His practice was to go over the list of patients in the care of the outgoing doctor and he would get a summary of the following: the issues that brought them to the ED, what was found on physical examination, what investigations had been done, any therapies that had been instituted or any consultants involved with the patients care. In addition to the patients he was taking over, he also had responsibility for new patients coming into the ED.

[179] With respect to Heather Brenan, Dr. Dowhanik was told about her presentation, she had swallowing difficulties causing dehydration and secondary to her dehydration, she had experienced acute renal failure. She also had a complaint of central chest pain and this had been investigated with a CT scan of her chest and a hiatus hernia had been confirmed as the cause. He was advised Heather Brenan was undergoing a gastroscopy at the Victoria General Hospital with Dr. Mikflikier and she would be returning to the SOGH at some point after that. Dr. Sokolies told

him if the gastroscopy was ok, the expectation was she could be discharged. He recalls discussing her progress throughout her stay, including the consultation with Nephrology. Dr. Dowhanik was aware her kidney function had improved and a Nephrologist in the community would follow her up.

[180] Dr. Dowhanik testified that, although he has no specific memory of the day, his practice would be to see any urgent, critical or unstable patients first and then follow up with other patients later on - particularly if he was waiting the results of investigations.

[181] With respect to the chart, Dr. Dowhanik said he believes he would not have reviewed the entire chart, but he would have reviewed the salient details, such as the Nephrology Report and the Consultant Reports. He was aware of the OT/PT Reports but cannot say if it is because he reviewed them on the chart or he was advised at handover. He said he did not see the Social Work Report and he did not have a specific recollection of seeing the Home Care Notes but he knew Heather Brenan was being assessed and there was a plan to have Home Care in her home. He was not aware Home Care wanted to see Heather Brenan again. He testified a patient would not be held in Emergency pending arrangements being made with Home Care. He does not recall seeing the Speech-Language Pathology Assessment or being aware of the recommendation of a blenderized diet.

[182] Dr. Dowhanik testified he would have reviewed the Integrated Progress Notes and Heather Brenan's vital signs. He recalls reviewing Dr. Micflikier's report and specifically, the Consultation Record. The relevant portion of this report was:

> She had increased fluid in the esophagus with exudate. Not biopsied. Has had trouble tolerating procedure. And the stomach products unremarkable. Etiology, the exudate was not clear. Doesn't have appearance of candida. Could not do biopsy as she was having difficulty tolerating endoscopy.

[183] Dr. Dowhanik also reviewed the medications administered during the procedure and the General Hospital Endoscopy Procedure Record.

[184] Dr. Dowhanik believes he was aware Heather Brenan's oxygen saturation level had dropped to 75% during the procedure.

[185] Dr. Dowhanik does not recall having Dr. Mikflikier's typewritten report and he does not think it was on the chart when he reviewed it.

[186] Dr. Dowhanik's overall impression from the gastroscopy was: Heather Brenan had esophagitis, the gastroscopy was not entirely successful in the sense that Dr. Mikflikier was not satisfied with the diagnostic information he was able to obtain, and he had to stop the gastroscopy abruptly because Heather Brenan could not tolerate the procedure. He felt the gastroscopy had almost been completed, in that the scope had been inserted all the way to the stomach, but there were some pending biopsies that were not performed. Dr. Dowhanik assumes the reason for the biopsy was to determine if Heather Brenan had a precancerous condition as a result of chronic inflammation - or burning of the esophagus. Secondly, he thought the biopsies would show if there were other diseases to be concerned about. In his view, the gastroscopy was pretty much complete. He felt that although the gastroscopy had not revealed the exact diagnosis of her esophagitis, it had ruled out a blockage or a tumor and Dr. Dowhanik felt Heather Brenan had the functional ability to swallow.

[187] Dr. Dowhanik recalls being told Heather Brenan had returned from the Victoria General Hospital and he went to see her and advised her of the results of the gastroscopy. He told her he wanted to repeat her lab work and he would see her after he had the results. He testified that he ordered a complete blood count, a check of her electrolytes, her creatinine and her urea around 8 p.m. He recalls he had reviewed her labs and chart and he had spoken to her nurse.

[188] Dr. Dowhanik said when he saw Heather Brenan she was sitting on the edge of her bed. She did not complain of any chest pain, or shortness of breath or any abdominal or leg pain. He did not record these observations until she returned to be resuscitated later that night. His explained he does not usually record negative findings. Heather Brenan appeared to be comfortable and he believes she was on oxygen.

[189] Dr. Dowhanik said he paged Dr. Micflickier twice that evening. He said Dr. Micflickier did not respond to either page. Dr. Dowhanik paged him because the reason for Heather Brenan's admission to the ED was esophagitis and the inability to swallow. Since Dr. Mikflikier had been her Gastroenterologist for some time, Dr. Dowhanik wanted to ask him what treatment he would recommend for Heather Brenan.

[190] Dr. Dowhanik said it is common when patients are sent out for diagnostic investigations, to receive a phone call if there is something unusual, critical or out of the ordinary. Normally, he said, you would get a report back or a phone call from the consultant saying this is our finding on gastroscopy and this is the recommendation we have for treatment of this issue. Since Dr. Micflickier did not

call, Dr. Dowhanik did not feel there was anything dangerous or abnormal to report and nothing unusual in addition to what had been contained in his report.

[191] When asked what he made of the fact Heather Brenan had desaturated during the gastroscopy procedure, he said several factors could have caused it. He said the medication she was given to sedate her could cause light-headedness or sleepiness that can affect your ability to breathe. This is particularly so he said, with the drug fentanyl, which was what was administered. He also said a scope sliding down your throat can cause breathing difficulty.

[192] Dr. Dowhanik received Heather Brenan's test results back shortly after 9:00 p.m. He reviewed the results and felt they were reassuring. There was nothing acute, there did not appear to be any cardiac disease and her renal function had improved and stabilized. He shared this information with Heather Brenan, telling her there was nothing concerning about the results and they discussed the discharge plan. He said Heather Brenan shared her concerns about her house keys, the need for a ride home and her concern about nutrition. She asked what type of nutritional supplements and foods she could intake and they settled on Glucerna as being appropriate. Heather Brenan also asked for a prescription for the esophagitis and he prescribed a proton pump inhibitor - namely Losec - which had been prescribed by Dr. Mikflikier in the past. This drug inhibits the production of acid in the stomach, which causes burning, and inflammation and swelling which can cause the swallowing difficulties. It allows the esophagus to heel. Dr. Dowhanik also prescribed the sleeping aid that she requested.

[193] Dr. Dowhanik said he spoke to the nurses, prior to seeing Heather Brenan, to get their input on the assessment of her abilities to manage at home and ensure a safe discharge. He recalls having this conversation when he first went to Pod 3. The nurse, Mr. Anderson, advised Heather Brenan had been up and around, she was able to toilet independently, she had been to the nursing desk without oxygen, was comfortable and doing well. He was aware OT/PT had cleared.

[194] With respect to whose responsibility it is to do the functional assessment - the doctor or the nurse - Dr. Dowhanik testified he relies on the nurses to deal with the functionality of the patient, since they have more direct contact with the patient. He said the nurses will ask him to assess and he expects if they have concerns about the patient's functionality, they will advise him of their observations.

[195] The Court did not take this to mean, he felt he was not ultimately responsible for the Functional Assessment of the patient, but that his expectation is, unless

there is an obvious issue, or he has been advised of an issue, he assumes the patient is functional. Dr. Dowhanik said he made the assessment of her functionality based on his understanding of OT/PT's comments, what he saw of Heather Brenan himself, his advice from the nurse that she had been mobile without oxygen, and having no indication from the nurse there was any issues regarding her functionality prior to discharge.

[196] Dr. Dowhanik explained his decision to discharge as follows:

> I wanted to be reassured that any active medical issues were, were addressed. And her renal function had improved, her dysphagia was addressed in the sense that it was, she had her gastroscopy, that's what she was kind of being held, that's what was, one of things that needed to be done while she was being admitted to the Emergency Department, and her Functional Assessment, her functional abilities were cleared by OT/PT.
>
> In my assessment of her in the department, the Pod 3, both from the opinion of the nurses and my own, I found her to be comfortable, not in any distress, she did not complain of any chest pain or shortness of breath, did not indicate to me that she was uncomfortable or she wasn't comfortable with the idea of discharge. And I think in another note I witnessed her, I, I had written a note that I'd witnessed she, she had been up at the desk on the telephone independent.

[197] Dr. Dowhanik was aware Mr. Didkowski had arranged for her transportation home and for a friend to meet her there. Heather Brenan was given instructions on her medications, advised to return to the ED if she had increased weakness or decreased oral intake and she was instructed to follow up with her own family doctor and Dr. Mikflikier.

[198] With respect to the medications Heather Brenan was on when she came into the hospital, Dr. Dowhanik testified he did not have a specific recollection of discussing those with her but his practice is to do so. He said he likely would have discussed whether she should restart certain medications. Although he did not testify to specifically having a conversation with Heather Brenan about restarting the Pradaxa for her atrial fibrillation, he said, in his view, the risk of restarting this medication outweighed the benefits given her renal failure and the low risk of stroke. He also said he would expect Heather Brenan to see her family doctor in due course and discuss whether she should go back on this medication.

[199] Dr. Dowhanik was asked specifically about Heather Brenan's ability to function without oxygen going forward, given she had been on various levels of oxygen during her stay and she was still on 2 litres of oxygen as of 7:05 p.m., on January 27. His response was, he had seen her up himself at the desk independent of oxygen, she appeared to be in no distress or short of breath when he talked to her; the nurses had said she was fine without oxygen and so he presumed her oxygen saturation was such that she did not require supplemental oxygen going forward.

[200] Dr. Dowhanik recalls seeing Heather Brenan leaving the ED in a wheelchair with a Health Care Aid.

VIII. Circumstances Of Heather Brenan's Death

[201] Ms. Northage received a call from Ms. Thompson at 10:30 p.m., advising her that Heather Brenan was being discharged. Ms. Northage testified it was fortunate Ms. Thompson called when she did, because she was out and would have missed her call. She went to Heather Brenan's home and opened the house. When Heather Brenan arrived by taxi at 11:00 p.m., the taxi dropped her in the back lane and left. Heather Brenan was standing by her back fence leaning on the fence and appeared to be very weak. Ms. Northage retrieved Heather Brenan's walker and Heather Brenan started walking towards the house. Ms. Northage described her as weak and slumping over her walker. Ms. Northage estimates it took Heather Brenan about 20 minutes to walk approximately 30-40 feet to her back door. She said Heather Brenan kept getting lower and lower over her walker and she had to shout at her to get up. Heather Brenan's voice was described as being 'garbled' and she was not making sense. They got as far as the back door and onto the landing when Heather Brenan collapsed. She landed face down on her landing and because of her size; Ms. Northage was not able to roll her over. Ms. Northage said, even if she could have rolled her over, Heather Brenan would have fallen down the back stairs. Ms. Northage called 911 and said it took 6 minutes for the Ambulance to arrive. Fire and Ambulance picked Heather Brenan up and took her to her living room and attempted to resuscitate her for 20 minutes. The Paramedics advised Ms. Northage they were taking her to the hospital and advised Ms. Northage to follow, which she did.

[202] Chris Rollwagen is an Advanced Care Paramedic and he is an acting Medical Supervisor. He has been a licensed paramedic since 1994 and has been with Winnipeg Fire and Paramedic Service since 2000. He and his partner were

dispatched to Heather Brenan's home at 11:32 p.m. on January 27, 2012. They arrived at 11:36 p.m. and Heather Brenan was in the back stairwell.

[203] The Fire Department had arrived seconds before the ambulance and two firefighters were with Heather Brenan. They moved her to the living room and commenced resuscitation. Their goal was to regain a pulse. They provided her with oxygen and started chest compressions and an IV for fluid and medication. Mr. Rollwagen reported Heather Brenan went into ventricular fibrillation, meaning her heart was quivering, but there was no heartbeat. They continued CPR and shocked her on the way to the hospital. They continued the medications and CPR until they got her to the hospital. Her pulse returned just as they arrived at the hospital. They reported to the receiving doctor in the ED, who was Dr. Dowhanik, and handed over Heather Brenan's care.

[204] Mr. Rollwagen was questioned as to whether they could determine the source of the cardiac arrest and he explained they run through a number of potential causes. In this case, they did not know what had caused Heather Brenan's collapse. He added that even if they had known she had a PE, there is nothing they could have done for it in the field.

4. January 28, 2012

[205] Dr. Dowhanik heard the code red and attended at the resuscitation room. He spoke with the Ambulance attendants to understand what had happened, what interventions they had performed and how the patient responded. He stated he was pretty startled to see it was Heather Brenan because he had just discharged her. He reviewed her Emergency Treatment for the Court. It indicated the Paramedics performed CPR, had intubated her and they had regained a pulse. In the resuscitation room, Heather Brenan was in full cardiac arrest. Her pupils were fixed and dilated and she was not responsive. She had no planter response, which indicated she had a profound injury to her brain. She was hypertensive and had chronic atrial fibrillation. Dr. Dowhanik performed a full resuscitation and in his words: "We performed pretty much every procedure that we could at the time to restart her heart and to maintain her blood pressure, maintain her oxygenation. The next step was to treat any potential reasons for the cause of the collapse."

[206] While her heart was restarted and she had a pulse, Heather Brenan had no neurological response when she was transferred to ICU. Dr. Dowhanik said she was critically ill.

[207] Dr. Dowhanik was questioned on his knowledge of the risk factors associated with DVT. He agreed prolonged bed rest, being overweight or obese, dehydration, atrial fibrillation and being over age 60 can all be considered risk factors. He also agreed there are a number of treatments to either prevent or treat DVT.

[208] Dr. Dowhanik was asked whether he had considered the risk to Heather Brenan of DVT or PE prior to discharge. He said that PE usually presents with acute shortness of breath or chest pain. He also said prior PE may cue a doctor to consider this. In Heather Brenan's case, he did not see any of those symptoms. Dr. Dowhanik also said he did not hear any complaint of a red hot swollen limb, which would be another cue and her cardiac workup was negative. From his perspective she had no acute coronary symptoms and so he did not consider her at risk of PE.

[209] When all of the risk factors, listed in the paragraph above, were put to Dr. Dowhanik in relation to Heather Brenan, he said he did not consider her having a DVT based on her presenting symptoms when she entered the ED.

[210] When she was brought back in by ambulance, Dr. Dowhanik testified he also did not consider she was experiencing a DVT Pulmonary Embolism. He said she did not present with the constellation of clinical symptoms typical in this situation. In his view, this was an unexpected result.

[211] Dr. Dowhanik acknowledged what happened to Heather Brenan has changed the way he looks at patients. He says PE is now a little higher on his list of potential reasons as to why a patient may have particular symptoms. He was also emotional in his testimony, as he told the Court what had happened to Heather Brenan had him considering quitting the practice of medicine.

[212] Ms. Northage said she talked with Dr. Dowhanik after Heather Brenan was treated in the resuscitation room. Her observation of Dr. Dowhanik was he looked like he had not slept for days. She said Dr. Dowhanik advised her he was the doctor who had discharged Heather Brenan and she asked him if he examined her before he sent her home. She said his answer was 'no' and she testified he said to her he would probably go home and not sleep tonight because he was so bothered by this. Dr. Dowhanik testified that he does not recall being asked this question or answering it as she said.

[213] Heather Brenan was admitted to the ICU under the care of Dr. Bojan Paunovic. Dr. Paunovic graduated from Medical School, at the University of

Manitoba, in 1995. He completed an Internal Medical Specialty in 1999 and a Subspecialty in Critical Care in 2001. Between 2000-2012, he worked extensively in Internal Medicine, attending wards for admissions and consultations and he worked extensively in ICU's in Critical Care. He works predominantly at the Grace Hospital and Health Sciences Centre. He currently works at Health Sciences Centre as the Regional Adult Critical Care Medical Director for the WRHA and is the Co-section Head of the Critical Care Program at the University of Manitoba.

[214] On January 28, 2012, he was covering the SOGH ICU, as the Attending Physician. He had not worked at SOGH previously. He worked Monday-to-Monday, available 24 hours a day and attended at SOGH, as needed, every day.

[215] The SOGH ICU has 7 beds and the unit provides care to people who need ongoing high-level support, including those who need mechanical ventilations and infusions of medications. There are four nurses who work in the ICU around the clock. In addition, there is Health Medical Officer (HMO) coverage - sometimes it is a resident or a Family Doctor or a subspecialty fellow who covers the ICU for urgent issues. They do not have the same experience as the Attending Physician and HMOs constantly communicate with the Attending Physician on urgent issues.

[216] In this case, Dr. Paunovic was contacted regarding Heather Brenan's care. He gave various orders during the resuscitation efforts. He understood she had been resuscitated with CPR and was undergoing ongoing resuscitation efforts, including medications required to maintain her blood pressure in order to maintain blood flow to her vital organs. He was aware she was on a mechanical ventilator. Dr. Paunovic believes, after discussing the matter with the HMO, he understood Heather Brenan was in significant shock and she was not responding to the maximum therapies being delivered. After discussion with the HMO, they decided that if Heather Brenan arrested again, they would not resuscitate, meaning they would not perform CPR or other therapies.

[217] Dr. Paunovic stated this decision was based on her extensive injuries which included: cardiac arrest, multi organ failure, significant brain injury, renal failure and multiple rib fractures. She was being treated with increasing amounts of medication, with no response, and she was on a mechanical ventilator. Heather Brenan, despite intensive treatment, continued to deteriorate. Dr. Paunovic explained CPR at this stage would not be beneficial to her and it was not going to be a successful treatment. Later in his evidence he further stated that, in this circumstance, CPR would be an inappropriate medical treatment.

[218] Dr. Paunovic assessed her on Saturday morning and she was continuing to deteriorate.

[219] Heather Brenan passed away just before noon on January 28, 2012.

[220] Dr. Paunovic was aware of the Advance Care Plan for Heather Brenan and he was aware she had indicated she wanted full treatment that would include CPR. Dr. Paunovic said the Advance Care Plan reflects the consent a patient gives *at a point in time* with the knowledge he/she has of their medical situation *at that time*. He said Heather Brenan filled out this form when she entered the ED with symptoms and complaints that were different from what she had when she returned to the ED. He explained the Advance Care Plan is not static and any informed consent must be based on the situation the patient is facing at the time. In Dr. Paunovic's opinion, given Heather Brenan's medical condition and prognosis in ICU, he would not consider the Advance Care Plan to be very informative, as it did not reflect an informed decision regarding her situation when she was returned to SOGH.

[221] Dr. Paunovic was questioned as to whether he considered the possibility Heather Brenan was having a PE and if he thought it was a possibility whether he would have treated it. He explained it was a potential diagnosis, although it is not reflected in his note. He said with respect to treatment, he may have done a CT if the test had been available at SOGH, which it was not. Dr. Paunovic added it would have been an academic exercise because there was no treatment that could have been administered to change Heather Brenan's outcome. The only thing it would have potentially changed was the diagnosis recorded in the chart.

[222] Ms. Northage testified she and Ms. Thompson sat with Heather Brenan in the ICU earlier the same day. Ms. Northage testified she had left the ICU for a time and when she returned Heather Brenan had passed.

[223] Ms. Northage testified that she had earlier contacted a friend who called Dana Brenan. Dana Brenan confirmed she received a call advising her mother had been discharged, collapsed at home and was taken back to the hospital. She immediately got on a flight home to Winnipeg. Ms. Northage and Ms. Thompson picked Dana Brenan up at the airport and brought her to the hospital.

[224] When Dana Brenan was picked up at the airport and advised her mother had passed, she said she was very shocked. At the hospital she viewed her mother's body, which she said was very upsetting because of the state of her mother's body and because she did not feel she was given privacy to see her mother.

[225] Dana Brenan recited a conversation Ms. Thompson and Ms. Northage said they had with an Administrator at the hospital at that time. Dana Brenan said she was advised the Administrator said she had no idea Heather Brenan had been in the ED earlier, discharged and then brought back. Dana Brenan was told this person was the one who called for a Critical Incident Review.

[226] Dana Brenan testified from the time she attended at SOGH, following her mother's death and throughout the process, she felt like the Administrator and the staff at SOGH were trying to "manage her". Dana Brenan wanted answers to a number of questions, including why life saving measures were not taken to save her mother and why life support was withdrawn. Dana Brenan set up meetings with the Hospital Administration to get the answers she sought.

[227] It appears there was a misconception on the part of Dana Brenan with respect to whether life support was withdrawn from Heather Brenan. It is clear from Dr. Paunovic's evidence, life support was not withdrawn. It is equally clear that Heather Brenan was in a highly unstable, deteriorating condition and in his opinion, death was inevitable. The question asked of him, was could you have kept Heather Brenan alive until her daughter arrived? His answer was clear; Heather Brenan was on maximum life sustaining therapies and she died while on those life sustaining therapies. To administer CPR to keep her alive until Dana Brenan arrived, was not appropriate because Heather Brenan had already suffered significant trauma from the treatment and would suffer further trauma with continued CPR to no end.

[228] Many of the witnesses who testified made comments and recommendations to the Court in response to the questions posed, as well as comments and recommendations as to how care can be improved in emergency departments generally. Those comments and recommendations will be considered in the context of the questions raised by the chief medical examiner.

IX. Examination of The Hospital Acute Bed Situation in Winnipeg

[229] As we know, Heather Brenan spent four days in the ED at SOGH. At one time, she was an admitted patient and then she was changed to a hospital 'hold'. This portion of the report will examine the acute care bed situation in Winnipeg generally and specifically at SOGH. It will address the question of why Heather Brenan did not get admitted to a ward at SOGH and why she was not transferred to another hospital where she could have been admitted to a ward.

[230] Lori Lamont, Patricia Bergal and Dr. Ricardo de Faria all shed light on these issues through their testimony. All three of these witnesses have dedicated a great deal of their careers to investigating and managing issues of "flow", or moving people through the hospital system. Flow affects the availability of acute care beds in hospitals.

[231] Before addressing the specific issue, it is helpful at the outset to understand the WRHA organization and the regionalization and specialties at various WRHA hospitals. Lori Lamont, at the time of her testimony, had just been appointed Interim President and CEO of the WRHA. Previous to her appointment, she was the Vice President Inter-Professional Practice and Chief Nursing Officer. She was also Chair of the WRHA Professional Advisory Committee, which is the senior Clinical Care Committee to the Health Region that reports to the Board of Directors. Ms. Lamont has a Nursing Degree and a Masters Degree in Public Administration. She has been in senior administrative positions with the WRHA for the past 10 years. In these positions, Ms. Lamont provides senior leadership to regional programs, including emergency, critical care, medicine, long term care and clinical education across six acute care hospitals and 39 long term care facilities.

[232] Ms. Lamont provided an overview of the WRHA organization. Relevant to this Inquest:

- the WRHA is one of five Regional Health Authorities in Manitoba. The CAO's of the respective regions make up the Board of Directors of the Regional Health Authorities of Manitoba. The purpose of this organization is to have consistency in health care across Manitoba
- the WRHA Board of Directors reports to the Minister of Health
- historically each hospital had its own Board Of Directors and they operated independently. With Regionalization, several hospitals devolved into one structure, being the WRHA
- a number of institutions are owned and operated by the WRHA, including the Health Science Centre, Grace Hospital, Victoria General Hospital and Home Care. The WRHA Board of Directors is responsible for these entities
- a number of other institutions, including Misericordia Health Centre, Concordia Hospital and SOGH are governed by their own Board of Directors, but work cooperatively with the WRHA with respect to the delivery of services through operating agreements and service purchase

agreements. These entities are all represented on Senior Management and operations committees within the WRHA

- the expectation is all hospitals will operate with consistency in service and planning under the WRHA model
- a matrix model is utilized to deliver approximately 30 clinical programs across the Region to certain standards. Not all hospitals deliver every program
- the Professional Advisory Committee is the Senior Clinical Care Committee of the Health Region and it is responsible for the clinical practice across all disciplines. It considers the role of the Physician in a particular type of care, the nurses' role and the role of the Allied Health Care workers. It is also responsible for Collaborative Care, which is the team education program in the health region
- each program has a Regional Program Team, including a Physician, a nursing leader and an administrative lead and they are responsible for setting standards, developing policy and making decisions around where and what services will be delivered in a particular hospital. The hospital is then responsible to deliver the services to the defined standards
- WRHA is organized along six paired community areas - and community services such as Home Care, public health, community and mental health services are delivered to these paired communities through a single administrative structure per paired community
- Home Care workers are employees of the Home Care Program. A certain number of those employees regularly work in the hospitals in the health regions. They will see patients in hospital and make referrals to the local office of the paired community closest to where the patients live. Pursuant to collective agreements, Home Care workers operate on a Monday to Friday, 8:30 - 5:00 p.m. schedule
- Manitoba eHealth is a supporting structure of the WRHA. It looks after all the information technology systems and services across the province
- in the Winnipeg Health Region, the Emergency Information System (EDIS) is used across the region
- SOGH is one of 4 community hospitals that largely serve their local neighbourhoods

- there are two tertiary (teaching) hospitals - Health Science Centre and St. Boniface Hospital
- there are 4 Long-Term Care/Rehab Health Centres
- there are 35 Personal Care Homes (WRHA operates 3 of them)

[233] The objective of Regionalization is to provide consistency in the delivery of health services in Manitoba. This is to be achieved by creating standards of excellence in programs and having hospitals deliver those services. Certain hospitals specialize in certain areas of care and not all services are available at all hospitals.

1. Patient Flow and Bed Availability

[234] Judge Preston issued a report on December 12, 2014, in the Brian Sinclair Inquest. Portions of the report were filed in these proceedings. In that report, Judge Preston did a comprehensive analysis of emergency departments, and he considered issues of delay, overcrowding, patient flow and other issues. This Court did not examine these issues in the same detail, or with the benefit of the expert evidence provided at the Sinclair Hearing. However, these issues all have an impact on the availability of acute care beds and several witnesses provided information on these issues. The Court does not intend to cover the same ground as Judge Preston did in the same detail. The Court will review the evidence given in this hearing and the Court will restate some of the comments and findings from the Sinclair Report.

[235] As a starting point, and to put the issues in context, it is helpful to understand what overcrowding is in the ED. Judge Preston, very articulately described it as follows:

> [452] If one thinks of a person presenting at the ED as the front end of the hospital, and a person being discharged from hospital after admission as the back end, the problem of delay or wait time at the front end is caused by the delay at the back end. From the perspective of the ED health care providers, delay commences in the ED waiting room. Persons wait to be triaged. They are waiting because the Triage Nurses are fully occupied with other patients. Persons who have been triaged are waiting to be seen by a physician. Physicians are waiting because there are no spaces or beds for incoming patients in the Emergency ward. Patients who have been triaged, seen by an

> ED physician and are in a bed in the ED cannot be admitted to a ward in the hospital. There is no room for them in the hospital wards. Many of the beds in the hospital wards are occupied by persons awaiting discharge from hospital and placement in personal care homes or other long-term care facilities.

[236] A paper from Accreditation Canada (the organization which accredits hospitals) was filed at the hearing. The paper addresses patient flow issues and it described the reason for overcrowding in ED's as follows:

> Overcrowding occurs when the demand for services exceeds the capacity of the emergency department (ED) to provide quality and timely care. Clients need to receive the right care in the right place and at the right time; however an organization's ability to do so is compromised when the ED becomes overcrowded. When overcrowding occurs, admitted clients stay in the ED and are cared for by the ED team instead of the designated unit and team. This creates an access block to the ED, resulting in prolonged ED wait times, diversion of ambulances, people leaving the ED without being seen, privacy challenges, poor quality care, increased risk to clients and poor quality work life.
>
> ED overcrowding is a system wide challenge. And its root is usually poor client flow (e.g. unavailability of inpatient beds, inappropriate admissions, delays in the decision to admit, delays in discharge and lack of timely access to diagnostic services and care in the community). Poor client flow results from a mismatch between capacity and demand. By evaluating client flow data and considering all sources of demand (emergency and planned admissions, and outpatient and follow up care), organizations can understand the pattern of demand. Once patterns are understood, organizations can develop a strategy to meet variations in demand, reduce barriers to client flow and prevent overcrowding. This strategy should be aligned with existing provincial and territorial indicators and strategies.

[237] With this backdrop, Ms. Lamont addressed the issue of patient flow, which in turn sheds light on the acute care bed situation. As she explained, the concept of patient flow is considered all the way from the Primary Care Physician, through Emergency, through the inpatient area to the discharge locations, whether that be

back to the Primary Physician, an alternate care setting such as a Personal Care Home ("PCH") or Home Care.

[238] Patient flow is critical to the smooth and efficient operation of hospitals. If patients get stalled - or create a bottleneck in any part of the system - it affects the entire system, including the availability of acute beds. As such, it is critical to move patients from diagnosis to treatment and to discharge in order to ensure bed availability throughout the system. There are many issues and factors that affect the smooth flow of patients through the health care system. Moreover, many people are involved with trying to improve patient flow through various initiatives.

[239] Ms. Lamont highlighted certain ongoing flow initiatives. Several are relevant to this Inquest. It should be noted, not all of these initiatives are in place or planned for each hospital, but the objective is to improve patient flow, overall.

[240] Ms. Lamont advised the three main focus areas of patient flow are:

A. Improving efficiencies within the Emergency Departments and looking at how and when clinical decisions are made.

B. Looking at the clinical decision making and activities of the inpatient area and inpatient teams and

C. The responsiveness and ability of systems outside the acute care hospital to facilitate timely discharges including looking at Home Care and the long-term care system.

A. Improving efficiencies within the Emergency Departments and looking at how and when clinical decisions are made.

[241] Ms. Lamont testified, a number of steps are currently being taken to address this issue, including:

- For specific types of complaints, nurses are authorized to investigate or begin standard treatments, so care is provided promptly and clinical information is available quickly for the treating doctor
- Improving access to diagnostic services in the ED
- A pilot project has been started, with the creation of a 6 bed Clinical Decision Unit at HSC in 2014, which is targeted at the population who are expected to remain in hospital for 18-48 hours for investigation and treatment. These patients are considered

inpatients for the duration of their stay and are under the care of House Medical Officers (HMO) for their daily care and under the care of a surgeon or specialist overall. This unit relieves the congestion in the ED and makes more beds available.

- A similar unit is planned for St. Boniface General Hospital.

[242] Ms. Lamont said not all hospitals have the volume of these types of patients to warrant a similar type of unit and this is the case at community hospitals such as SOGH. However, the WRHA may consider designating a small number of beds at community hospitals in an existing unit to achieve the same purpose.

[243] It should be noted, this is the type of unit Heather Brenan would have been considered for if she had been admitted to SOGH on a short-term basis, if such a unit had been available.

B. Looking at the clinical decision making and activities of the inpatient area and inpatient teams, initiatives include:

- Improving acute hospital length of stay by identifying barriers to discharge early in the process and addressing those barriers
- Attempting to discharge as early in the day as possible
- Reducing the number of days people waiting for alternative care placements remain in the ED
- Developing a Regional Overcapacity Protocol, to address seasonal or unexpected surges in the hospital system demand including Individual Hospital Protocols
- Improving Home Care Services.

C. The responsiveness and ability of systems outside the acute care hospital to facilitate timely discharges including looking at Home Care and the long-term care system.

[244] Ms. Lamont explained delays in getting either Home Care, or long-term care beds, results in longer patient stays, while patients wait for placement elsewhere in the health care system. Ms. Lamont explained for example there are vulnerable populations; people with mental health issues or people who are homeless who need special arrangements made on discharge. This means beds are taken up by people on a wait list and those beds are not available to new patients seeking admission from the emergency departments.

[245] Several initiatives are underway to alleviate bed shortages and the flow issues in hospitals, including:

- programs with Home Care and the Department of Housing to deal with vulnerable populations, including the homeless. Programs directed at complex cases are being worked on with community partners, but all of these initiatives take time and resources
- the availability of PCH spots is an issue. Ms. Lamont explained there has been no increase in PCH capacity in the past few years. Ms. Lamont said this would continue to be an issue into the future as baby boomers require more PCH beds. There are plans to increase capacity in this area, but capital projects will not see results for another 4-5 years.
- a 2013 paper, authored by the Manitoba Centre for Health Care Policy, indicated each year 133,000 inpatient hospitalizations were provided in Manitoba.
- the highest user of hospital days is the medical program. Alternate Level of Care patients (ALC) is the third leading cause of the use of hospital days. These are often elderly people, in poor health, waiting for placement outside a hospital setting. Until they have the alternate setting they need, they will continue to take up acute beds in the hospital.
- other ongoing initiatives include the creation of Quick Care Clinics to take some of the strain off the ED. These clinics are staffed by Nurse Practitioners and they see people who may otherwise attend at the ED.
- SOGH has opened up 9 beds for people waiting to be panelled for a PCH and other hospitals have tried to do the same. The WRHA tries to 'cluster' these people waiting for PCH beds in a limited number of hospitals across the region. This allows WRHA to deliver the medical and nursing care they need in specific locations. Currently there are 37 such beds across 3 hospitals, including the 9 at SOGH. These are beds that would otherwise be used for other hospital programs or acute care.

[246] The above initiatives are clearly important as the WRHA and its community partners attempt to address the issue of flow. Several of the community initiatives are aimed at improving flow of patients to discharge and addressing issues in the

community so that patients do not have to return to the ED. The Court supports these continued efforts. Several of these initiatives appear to be consistent with the recommendations made in the Sinclair Report.

[247] Ms. Lamont addressed the flow situation at SOGH specifically. She advised SOGH was performing very well until November, 2011, when the Grace Hospital Orthopaedic Program (all orthopaedic trauma cases regarding those injuries resulting from a fall or accident, etc.) was transferred to SOGH. The Grace Hospital was no longer providing this service but would increase its capacity to accept other acute emergency surgeries.

[248] Ms. Lamont explained this change did not change the overall number of beds available in the region; however, it did cause a short-term increase in the requirements of Bed Utilization at SOGH. Prior to November, 2011, SOGH was not utilizing its full surgical bed capacity, while Grace Hospital was over capacity. SOGH had been admitting medical patients to the surgical beds. With the change, those surgical beds were no longer available to SOGH for the overflow of medical patients.

[249] This change in programs was a concern and had been raised by Dr. de Faria with the WRHA Executive. Specifically, he was concerned this change would cause a shortage of medical beds at SOGH. Ms. Lamont acknowledged there was an effect on patient flow and length of stay within SOGH. She also said this increase worked itself out in a few months.

[250] Ms. Lamont explained hospitals are limited by their bed capacity overall. There may be limitations in terms of funding, physical space and staff, which prevent simply opening more beds at any particular hospital. At times, as was the case in January, 2012, SOGH was over capacity. That is, it had more patients than beds and it meant patients would sometimes be in lounge spaces, or a third bed would be put in a room meant for two beds, or space was used for patient care, which would not normally be used. Ms. Lamont said, when this happens, it is not usually an event limited to a single hospital, but it can happen across the health care system.

[251] Given that overcapacity issues usually affect more than one hospital, Ms. Lamont said it is difficult to transfer a patient from one hospital to another. It can be done on occasion, but other factors also must be considered. These factors include, whether the receiving hospital provides the same programs as the transferring hospital. So for example, a kidney dialysis patient cannot be

transferred to a hospital whose specialty program is orthopaedics. Patients must be moved to the same program in an available bed.

[252] Ms. Lamont testified that between January 24 - January 27, 2012, SOGH ED was fully staffed and the total daily visits for the four days were on average 124 patients. On average in January, 2012, two people per day were waiting for admission to a bed. The specific statistics of people waiting for admission on the days in question was as follows:

- January 24 2 people
- January 25 4 people
- January 26 7 people
- January 27 3 people.

[253] These statistics show a much higher number of people waiting for admission than the monthly average.

[254] Ms. Lamont said recently SOGH has made improvement to its ED visits; the number of ED visits has dropped off over the last two and a half years. She believes this is due to the various initiatives aimed at relieving the strain on EDs. For example, there has been an improvement in the number of Primary Care Providers and Family Physician offices opening in the Seven Oaks area. There has also been the introduction of Quick Care Clinics in neighbourhoods to take the strain off the ED for non-urgent cases. The WRHA is trying to create a communication loop with these Quick Care Clinics so that information can be shared between the clinic and the ED to enhance the care given to patients.

[255] Ms. Lamont testified the WRHA is committed to addressing patient flow as a priority. As she said, until they have made the level of improvement they need to, this will remain an issue for the hospitals.

[256] Patricia Bergal spoke about Patient Flow. Ms. Bergal has, among other accomplishments and certifications, a Bachelors of Nursing, as well as a Masters of Nursing, and she has a Certified Health Executive designation through the Canadian College of Health Leaders. She has been the Nursing Director in Emergency Medicine in Winnipeg and is currently the Regional Director Utilization for the WRHA; a position she has held since 2002. In that capacity, she works with all Winnipeg hospitals, all Community and Long-Term Care Programs on strategic matters, and day-to-day operational issues related to access to care, discharge planning, and transition planning, with a view to ensuring patients get the right level of care, with the right provider, at the right time. Patient Flow from

a Regional perspective is her focus. She co-chaired and has sat on many committees, whose purpose is to address patient flow issues.

[257] Ms. Bergal walked the Court through the services provided at each hospital and she spoke to the number of beds available in each program. She advised the Court that not all programs are available at all hospitals. She confirmed the total bed count at SOGH in April, 2011 was 293, and as of April, 2012, it was 299. The difference is accounted for by the shift in surgery beds transferred from Grace Hospital to SOGH.

[258] Documents filed indicated the programs available and bed count at SOGH in April, 2011, were: Critical Care (ICU) - 7 beds, Family Medicine - 108 beds, Mental Health - 19 beds, Rehabilitation - 76 beds and Surgery - 64 beds. In April, 2012, the programs and bed count at SOGH were: Critical Care (ICU) - 7 beds, Family Medicine - 108 beds, Mental Health - 19 beds, Rehabilitation - 76 beds and Surgery - 70 beds. There is a notation on this document reflecting the increase in surgical beds due to the move of orthopaedics from Grace Hospital. There is a further notation that explained PANSU (Post Acute Neurosurgical Unit) was moved from SOGH to Grace Hospital in January, 2012. This change resulted in a net increase of 6 beds to SOGH.

[259] Ms. Bergal walked the Court through Weekly Flow Reports for the WRHA for the period of January 16-22, 2012 and January 23-30, 2012. The Weekly Flow Reports are an overview of the hospitals (Concordia, Grace, SOGH, Victoria General, Health Sciences Centre and St. Boniface Hospitals) activity and the capacity to move patients through the system. The reports look at a number of factors, including the number of patients in the ED, as well as the number of inpatients in the medicine and family medicine programs. The focus is on medicine and family medicine areas, because 90% of all admissions that come through Emergency are admitted to medicine and family medicine programs. In addition, the reports show how many people are in hospital waiting for Home Care services and long-term placement. The Weekly Flow Charts revealed, among other statistics, the following:

- during the week of January 16-22, SOGH was the second busiest hospital in Winnipeg with 780 ED visits that week. This has been a consistent trend for several years
- of the 780 visits, 44.6 % were CTAS 4 or 5's - representing the least urgent of all ED visits

- 27 people, or 3.5% of the total weekly visits, remained in the ED at SOGH for longer than 24 hours. This is the lowest number of patients remaining in the ED for more than 24 hours of the group of hospitals, other than HSC.
- at SOGH, the medicine and family medicine programs were at 108% occupancy - meaning they were over capacity for the number of inpatient beds available
- at SOGH for the week of January 23-30, 2012, the number of weekly ED visits increased to 871
- at SOGH, 19 or 2.2% of those people remained in the ED longer than 24 hours. This is the lowest number of all of the hospitals.
- at SOGH the occupancy rate for medicine and family medicine was 103% which is over capacity. So despite more visits to the ED, fewer people were in the ED more than 24 hours, and while family medicine and medicine were over capacity, that percentage dropped in the second week

[260] Ms. Bergal said when looking at the WRHA statistics versus Canadian statistics generally, it appears Manitoba is an outlier - patients at ED in Manitoba tend to remain longer in Emergency and there are greater numbers of people who are in the ED, for more than 24 hours. This is despite the fact Manitoba appears to have more beds available per capita than other organizations. The research is not clear as to why this occurs and there is no current research to explain it.

[261] Ms. Bergal testified she examines patient flow on a daily basis. She has information on how many people are in the EDs, from the waiting room throughout the department; how long they have been there (i.e. 4 hours, 8 hours, over 24 hours); how many are waiting to be admitted; and what the bed availability is.

[262] With this information, Ms. Bergal can determine what capacity and access hospitals have. If necessary, and based on the information available to Ms. Bergal, she will convene a Regional Conference call with a representative of Acute Care from each hospital, the Utilization Manager at each hospital, representatives of Long-Term Care Programs and Home Care. They discuss the status of the facilities recognizing, as she says, the situation is always fluid and will change throughout the day. They determine how many patients will be admitted and where. Ideally, as she says, there are beds for all, but if not, consideration is given to those with the greatest needs and those patients are prioritized. Factors that go

into the decision include: how ill a person is, if there are signs of recovery, if the patient needs to be isolated, the gender of the patient, and who are the sickest of the sick. All of these factors can affect acute bed placement.

[263] The Bed Utilization Manager at each hospital does not have a say in whether someone is admitted - that is the doctor's responsibility - but they do have input into bed placement and bed assignment. Utilization considers who is in the hospitals already and where (i.e. family medicine versus, surgery beds); if people will be discharged; if patients need to be transferred from ICU to another program (i.e. medicine); how many people are in beds waiting for a PCH and if there are any available; and how many temporary beds are open. The point being, many factors are considered and all of these factors can affect acute bed availability.

[264] Ms. Bergal advised, on January 24, 2012, there were 29 medicine patients in temporary surgery or rehab beds. On January 25, it was 21 and on January 27 it was 19. Heather Brenan, had she been admitted, would have been admitted to a medicine program. In addition, there were 6 people in beds, as hospital 'holds' waiting for Home Care Services before they could be discharged and there were 16 people who were paneled for a PCH bed, but none were available. All of these people are taking up acute care beds that could be used for other patients.

[265] Ms. Bergal explained the situation was not much better at SOGH on January 25. In addition to a similar numbers of patients waiting to be admitted to acute care medicine beds, there were four new admissions from the ED, including Heather Brenan, and there were patients in ICU, waiting to be transferred to acute care beds.

[266] The situation did not markedly improve on January 26.

[267] The above numbers show SOGH was incredibly busy and it did not have enough acute care beds for the admitted medicine patients who needed them. Heather Brenan was caught in a group of people hoping, and expecting, to be admitted to a medicine bed.

[268] Ms. Bergal said there is a protocol in place within the Utilization Management Software System that allows a nurse caring for the patient to assess a patient's readiness for discharge. The nurse inputs information into the system including: the reason for stay, vital signs, and the patient's degree of stability. The system will consider if the patient is ready for discharge. If the patient meets the criteria, the level of alternate care is considered and if the care is available, the patient is discharged.

[269] Ms. Bergal advised that in January, 2012, she might not have had specific information about Heather Brenan and the length of time she had been in the ED. She said the EDIS system, which she uses to access the Bed Utilization information, might not have been available to her in her office at that time.

[270] She testified that if she did see this type of information today, she would likely raise it as a concern on her conference call and gather further detailed information. Dana Brenan's counsel asked if this type of information should be flagged. Specifically in this case, by January 27, Heather Brenan had been in the ED for 4 days. Ms. Bergal's response was a flag of this type is a good idea, but the ED staff would have to be aware of this information and would discuss it in handovers. In her view, it is not who raises the flag, as long as it gets raised.

I therefore recommend:

The WRHA should consider implementing a flag within its Utilization System so that any patient in the ED, beyond a certain number of hours, as determined by the WRHA, should be specifically considered by the Utilization Team for follow up.

[271] Ms. Bergal said that between January 24-27, she was concerned about the capacity to admit patients at both SOGH and the Victoria General Hospital, and she was concerned about Health Sciences Centre and its surgical capacity. These sites became her priority. What she tries to do to relieve the stress on a particular hospital is: move patients to another hospital, if possible; contact Home Care for additional services; revisit a PCH space; and ask that another look be taken to see if anyone can be discharged from a hospital to a long-term care facility. She looks to see if she can transfer patients from a hospital at over-capacity to a hospital that has capacity available. The challenge in these cases is matching the patient needs to the proper program (i.e. a surgical patient to a surgical bed), while balancing all the other relevant factors.

[272] As Dr. Swirsky testified, many factors affect the ultimate admission decision. In Heather Brenan's case, she was considered to be improving and she was awaiting tests that would clarify her acute status. Given the number of patients competing for acute beds, priorities were considered and Dr. Swirsky's conclusion was there were other patients whose urgent care requirements were assessed to be more serious than Heather Brenan's. As such, Heather Brenan was taken off the list of patients to be admitted.

[273] Ms. Bergal spoke about an over-capacity protocol. While the Court does not intend to go into this Protocol in any detail, it notes it was one of the

recommendations from the Sinclair Report. Ms. Bergal said at this stage the Protocol is not complete in a comprehensive document but it is in the process of being completed. There are a number of guiding principles that have been approved and it now needs to move to the stage of being written.

I therefore recommend:

The WRHA move towards finalization of the regional overcapacity protocol.

[274] Ms. Bergal confirmed there have been numerous initiatives between 1998 through 2015 designed to enhance utilization in the hospitals. One document filed outlined over 70 initiatives for which the WRHA has received funding or which represent internal processes designed to address flow issues. The initiatives recognize that Emergency Room overcrowding is a multifaceted problem and sustainable solutions can only be achieved by enhancing the linkages throughout the entire health care system.

[275] Ms. Bergal's evidence makes it clear that people who are in hospital beds, awaiting long-term placement, to PCHs for example, have a profound impact on the system as a whole. Similarly, she was clear; managing patient populations has to include a consideration of the capacity of the program, as well as the needs of patients. The mantra "the right care, the right provider and the right time" is taken seriously and governs decisions including: who gets a bed, in which program, at which time. Until the flow issue and all of its interrelated complexities are addressed in a comprehensive and sustainable manner, the ability to utilize acute beds in hospital for the intended purpose, with the right person in the right bed, receiving care from the right health care provider, will remain a challenge.

[276] Ms. Bergal stated the recommendations from other Inquests have been helpful, particularly in planning additional capacity in long-term care facilities. The problem, as she pointed out, is the cycle time needed for actually having the facilities approved, built and occupied. In her view, the WRHA has to look at its processes related to additional programming, treasury board approvals, tendering and construction of these facilities. Ms. Bergal said currently underway, there is a 10-year capital planning exercise to look at long-term care.

[277] Dr. Ricardo de Faria is the Chief Medical Officer at SOGH. He was also the Acting Head of the Emergency Program at the University of Manitoba, as well as Head of the ED at SOGH, for approximately 10 years. Dr. de Faria recently obtained his Masters Degree in Business Administration from the University of Athabasca.

Dr. de Faria is deeply involved with eHealth and is responsible for rolling out the Electronic Department Information System (EDIS) in various EDs in Winnipeg and across the province. Dr. de Faria gave evidence from his perspective, as Chief Medical Officer at SOGH. Accordingly, his evidence is largely focused on SOGH and its performance.

[278] Dr. de Faria reviewed for the Court, the performance of SOGH ED over time. He also reviewed SOGH ED admissions, holds, beds available, etc., as of January, 2012.

[279] As he explained, SOGH underwent a transformation in 2007 to address issues that impacted the number of patients admitted to SOGH. Prior to 2007, family doctors did have care of the patients who were admitted but who remained in the ED. There was a doctor of the day on call, and that doctor would take responsibility for all the admitted patients. However, the system was such that one doctor could get one patient on any given day and another doctor could get 20. This was inequitable and it was not a viable system.

[280] In 2007, SOGH eliminated admitted patients from the ED by admitting the patients directly to the wards. At that time, the beds were available. A block system was introduced where each doctor would get 5-6 ED patients, which worked well when the beds were available. SOGH underwent a process transformation and improved the efficiency of the ED. SOGH's admission rates improved substantially.

[281] In addition, the surgical program left SOGH and went to the Grace Hospital. This left additional space at SOGH for admitted patients. At the same time however, the Grace Hospital now had additional surgical patients, as well as the orthopaedics program.

[282] Dr. de Faria explained SOGH ED became one of the most efficient EDs in the WRHA system. It was so efficient that, when SOGH built its new ED, it did not include an observation unit. The observation unit was where family doctors had formerly looked after admitted patients.

[283] The fact SOGH was efficient, and a top performer, is supported by a number of statistics. Dr. de Faria reviewed these with the Court and they showed, even though SOGH has a smaller bed base than many other WRHA hospitals, it is the second busiest ED of the WRHA hospitals, next only to the Health Sciences Centre, which has much larger capacity. SOGH, versus other WRHA hospitals, has the least restrictions on admission and its processes have been designed to

make sure once a patient is admitted - provided there is a bed - the patient moves to a ward. Its performance in finding an acute bed for admitted patients was outperforming all other WRHA EDs and that had been the case historically. In fact, Dr. de Faria advised SOGH was one of the top performers in the country in this regard.

[284] Dr. de Faria spoke to the change in late 2011, when the WRHA Executive made the decision to move the Orthopaedics Program from the Grace Hospital to SOGH. As explained above, this change meant the surgical beds that had been used as family medicine beds, were no longer available for that purpose. The reduction in the acute bed base for family/internal medicine, and the influx of orthopaedic cases, affected SOGH's performance starting in November, 2011.

[285] In Dr. de Faria's words, this change resulted in a "sudden packing of the emergency department". He raised concerns about the change to the WRHA Executive before it happened, as he knew it was going to be a problem. Dr. de Faria explained that the SOGH was approximately 24 beds short of what he believed it needed for family medicine admissions.

[286] From a Regional perspective, he felt the Grace Hospital's problem was just transferred to SOGH and as a result, the hospitals would just have to 'share the pain'. This meant, as there was an issue at the Grace Hospital, there was a transfer of a program to relive this pressure and from his perspective, this created pressure at SOGH.

[287] Ms. Bergal spoke to this concern from a Regional perspective. She said the Regional Surgery Program Group heading up this change would have worked with Grace Hospital and SOGH, as well as the other sites that provided orthopaedic services, to consider how it could consolidate the orthopaedics service to accommodate all patients. Senior Management of the WRHA would have approved the change. And although there was recognition there would be an increase in traffic at SOGH, and the surgery beds available to medicine patients would no longer be available at SOGH, from a Regional perspective, the WRHA also had to consider the needs of the surgical patients.

[288] Dr. de Faria also advised, in January, 2012, ED doctors were responsible for all patients physically located in the ED, whether they were admitted or not. This was unlike the situation prior, where family doctors looked after admitted patients physically remaining in the ED. This factor, along with the lack of available beds, and the transfer of orthopaedic patients from Grace Hospital to SOGH, created a bottleneck in the system.

[289] Dr. de Faria reviewed the bed availability at SOGH over the period of January 25-January 27, 2012. He explained SOGH has a bed base of 286. Of those 286 beds, 76 are Rehabilitation beds, 50 are Surgical, and 108 are Family/Internal Medicine beds. During the time period between January 25-27, 17-23 beds were used for 'alternate level of care' patients - patients who no longer need acute care, but who are waiting for placement elsewhere or Home Care resources; 19-21 beds were being used for Off Service patients - patients who should be in Family Medicine beds, but who are elsewhere in the hospital, such as Geriatric Rehabilitation or Surgery beds; there were between 4-9 hospital holds - patients waiting for various Home Care services to be finalized before being discharged; and 9-15 panelled patients waiting for spaces in PCHs. The data reviewed by Dr. de Faria said there was 100% occupancy at SOGH during January of 2012.

[290] These numbers, particularly the Off Service patient numbers, were higher than any other hospital when the available bed bases are factored in. This demonstrated the fact SOGH did not have enough Family Medicine beds available for the number of patients who were arriving in the ED.

[291] Dr. de Faria testified there is recognition from the region that SOGH does not have enough medicine beds and the difficulty in creating additional beds includes a lack of physical space. He said there are currently 19 geriatric patients occupying an area for 30 patients. These patients do not need to be in an acute care hospital but they still need care. The Mental Health Program agrees these patients should not be in a hospital and there is a long-term plan to move these patients out of SOGH and replace this space with 30 medicine beds. As Dr. de Faria says, this takes planning and funding, as it has to be managed within the priorities of the system.

[292] Given the shortage of medicine beds at SOGH, the above plan appears to be one way to address the SOGH acute bed shortage.

I therefore recommend:

The WRHA review the initiative to move 19 geriatric patients out of SOGH to a long-term care facility and convert that space to 30 medicine beds, and consider whether the WRHA can move this initiative to a higher priority within the WRHA plan overall.

[293] Dr. de Faria and others testified that January and February are typically busy times in the ED and January of 2012 was no exception. In January, 2012, there

were 3840 patients who visited the ED. In February, 2012, the number was 3656. Of those patients presenting at the ED, in January, 2012, 7.63% and 8.18% respectively, were admitted. These numbers were somewhat higher than the historical average.

[294] There was an average of 121 people per day who attended at SOGH ED between January 24-27, 2012. It is not just the number of patients who present in the ED that determines how busy the ED is. As was explained, one also has to consider the acuity of the presenting patient, as this has a direct affect on the amount of time dedicated to the patient.

[295] Dr. de Faria explained the Canadian Triage Score ranks the seriousness of acuity of a patient. A C-TAS1 complaint is the most serious and indicates a patient is near death. A C-TAS5 reflects the least serious acuity; for example, a sore throat. Heather Brenan presented initially as a C-TAS3 on January 24. When she returned January 28, she was a C-TAS1.

[296] Dr. de Faria explained that currently at SOGH, the number of C-TAS4 or C-TAS5 (less urgent) seen by doctors, accounts for approximately 40.5% of all ED patients. Regionally, the WRHA would like to see that number reduced to 20% and is taking steps, including implementing the Quick Care Clinics, to try to address that issue. A further goal of the WRHA is to have these patients seen and diagnosed within less than 4 hours. SOGH on average reaches this 4-hour goal only 54% of the time. That is still a much better performance than other hospitals. For example, Grace Hospital only reaches this goal 26% of the time, on average.

[297] A further goal is to have 50% of patients, who end up being admitted, remain in the ED less than 8 hours. All WRHA hospitals are far from this goal as Dr. de Faria indicated, only 5-7% of patients are seen within this 8-hour time period. This is one of the biggest barriers to 'flow' in the hospitals, according to Dr. de Faria. As Dr. de Faria said, SOGH performs better than many of the hospitals. For example, through the period of April 1, 2011, to March 31, 2012, SOGH only had 1.0% of patients wait longer than 24 hours to be admitted. While this is clearly not the goal, all other WRHAs had a higher percentage than that.

[298] With respect to health care resources, Dr. de Faria said the WRHA is limited in its ability to ramp up resources during peak times. The limitations include nursing and physician contracts that specify hours of work. However, Dr. de Faria did say SOGH could pull from its float pool, which is a group of nurses or Allied Health Care workers who can provide relief in different areas of the hospital. In

addition, SOGH tries to use Physician Assistants to ease the strain, but again there are contractual limitations on their use.

[299] Other factors that generally affect the use of acute care beds at SOGH include :

- the Interlake Hospital Region not being able to keep its ED open therefore, those patients were transferred to SOGH
- SOGH has a large number of dialysis patients that are increasingly ill and require a lot longer lengths of stay
- the availability of providers generally. There has been a general change in the culture of ED doctors where they are now more inclined to strive for work/life balance than ED doctors of the past, and they are less inclined to be on call from morning to evening every night
- Rationalization - there has been a reduction in the number of specialists available in various disciplines such as ear, nose, throat, and urology (as examples) therefore, these specialties are not available in all locations. Rather, these specialists have been centered in particular hospitals, building centres of excellence. However, this Rationalization also means not all programs are available at all hospitals and people must now travel to those locations for programs or consultations
- a shortage of Nurse Practitioners in the Minor Treatment area at SOGH

[300] These factors all impact acute bed availability. Patients are expected to be placed in the right program. If a patient presents with an orthopaedic issue for example, they should not be placed in a medicine bed. SOGH was putting non-surgical patients into surgical beds and when that ended, SOGH was in a bed crunch.

[301] A number of the ED doctors who testified, made recommendations for relieving the pressure on the EDs. Those recommendations are made from their particular perspective. Some of the recommendations included:

- Dr. Whyte:Suggested having General surgeons as consult surgeons available at SOGH. He believed this would help because currently, having to transfer patients to other hospitals to access surgery (i.e. gastroscopy), takes time and keeps the space open for

those patients. This need is heightened because SOGH is the second busiest ED in the Province.

- Dr. Whyte also stated that an Emergency Room could not also be an inpatient medical ward. He said EDs cannot function as both. EDs need the time, ability and resources to deal with the new people coming in, as well as, the people who are there for a short time. He stated the doctors have to be able to transfer the people who need admission somewhere physically different and under the care of somebody else. Dr. Schneider also shared this sentiment stating that patients, who are now under the care of a family physician, need to be moved to a different location in the hospital and out of the ED.

- Dr. Schneider also said it would be helpful to have another doctor deal with emergencies on the wards. Currently the ED doctors get called to a ward for emergencies and it lessens their ability to concentrate on the patients in ED. He does not believe this issue had an impact in Heather Brenan's case, but overall, it would help improve care in the ED.

- Dr. Schneider also suggested a Step Down Unit at SOGH. This would be an area for patients too sick for a ward and not sick enough for ICU. At SOGH these patients remain in the ED. With a Step Down Unit, they could be placed in a separate area and monitored. These patients require a higher level of care than those patients in the ED. He does not believe Heather Brenan would have been a candidate for this type of unit but overall it would take stress off the ED to have these patients moved somewhere else. In his view, such a unit would improve patient flow. Dr. de Faria stated he would strongly support such a recommendation, within the existing bed base of the hospital.

- Dr. Dowhanik recommended allowing ED Physicians to direct a ward to take a patient. Dr. de Faria said this is a constant struggle between EDs and the wards, and this is not an issue unique to SOGH, or Winnipeg, but it is an issue across the country. Dr. de Faria explained there is a process in place to move a patient to a ward and once a patient is admitted, the forms are faxed to the ward and the patient should be up there in 20 minutes. If for some

reason the ward cannot take them at that time, they have to say so. Dr. de Faria said it would be helpful to know what beds, on what wards, are cleaned and available. He would like to incorporate this into the electronic system but it has not been to date. He said there is consideration of doing a pilot project at SOGH and the Health Sciences Centre to see if communication can be improved so everyone is notified when a bed is cleaned and available on a ward. He also suggested there would have to be a culture change, as there are times when a ward does not want to accept a patient and there are times when the ED does not like sending patients up to the ward (i.e. during shift changes in the ED.)

- Dr. Alecs Chochinov, whose evidence will be reviewed later in this report, recommended the use of more Hospitalists, Physician Assistants and Nurse Practitioners. He would prefer a Hospitalist model to a Step Down Unit. In his opinion, this would also deal with the issue of admitting patients, as raised by Dr. Dowhanik. A Hospitalist is someone trained in Family Medicine and ideally another specialty, such as Acute Care. In Dr. Chochinov's model, the Hospitalists would be able to admit directly and look after the more acute patients not sick enough for the ICU. They could not say no to an ED doctor who wants the patient admitted and the Hospitalist takes over responsibility for that patients care wherever they are in the hospital including, in the ED. This approach would free up the ED doctors. Dr. Chochinov thought this was a model being considered by the WRHA.

[302] Several of these ideas could be addressed with the creation of a Clinical Decision Unit in a specific space out of the ED at SOGH or by integrating a hospitalist model as suggested by Dr. Chochinov.

[303] The change SOGH has already made, where family doctors are now responsible for the care of admitted patients from the ED, is helpful in addressing some of these issues.

[304] In considering all of these recommendations, the Court is mindful it is not an expert on hospital administration. It is also mindful of the testimony which indicated what happens at one community hospital is expected to happen at all. However, it is equally clear some alternative model should be investigated which relieves the stress on the ED in times of overcapacity.

I therefore recommend:

The WRHA consider the feasibility of creating either an alternate space at SOGH for a unit similar to a Critical Decision Unit, where ED doctors can transfer patients, who are expected to remain in the ED for over 24 hours, to the HMO, or the WRHA consider the feasibility of a Hospitalist model at SOGH, where care of a patient is transferred to the care of a Hospitalist wherever the patient is located in the hospital.

[305] With respect to doctors making the decision to admit and transfer patients elsewhere, as suggested by Dr. Whyte, the Court was advised there are models in different regions that support this idea. Ms. Bergal thought there was some merit to this as it could move the process along. However, she stated you still have to have the inpatient bed available to transfer the patient to. Again, she cited the blockage of people waiting for long-term care taking up acute beds as an issue. Dr. de Faria said he is the person at SOGH who can make these decisions. Therefore, I make no recommendation in this regard.

[306] With respect to understanding bed availability in the hospital, Dr. de Faria suggested incorporating an electronic system so doctors in the ED know what bed is available and when. There is merit in this because understanding the opportunities and constraints regarding acute bed availability may help doctors find a bed when needed.

I therefore recommend*:*

The WRHA consider the feasibility of adopting a pilot project at SOGH so that bed availability information is shared with the ED – and the ED is informed as to when the bed is cleaned and available. This information should be shared in paper format until it can be made available in electronic format.

[307] Until the systemic issues, including patient flow, are addressed on a holistic level, which includes addressing the issue of the shortage of long-term care facilities, facilities for vulnerable and other special needs patients, the issue of overcrowding in the ED's and lack of acute bed space, will not be resolved. It is clear from the evidence presented; this is not an issue unique to SOGH, or the WRHA or Manitoba. Several recommendations were made in the Sinclair Report in regard to this issue. The WRHA has several initiatives underway to deal with this problem. However, it is not the WRHA's problem alone. Provincial initiatives to increase long-term care facilities are underway, but the process is long and it is slow. Given the aging population in Manitoba, this issue will continue to

put pressure on the health system in Manitoba. Unless more money is dedicated to the health system as a whole, there will be no resolution to the acute bed shortages in Manitoba.

X. Examination of Hospital Policy Regarding Hospital Discharge of Patients at Night, Particularly Those Who are Elderly, Frail and Who Reside Alone

[308] As we know, Heather Brenan was discharged late at night and sent home in a taxi. Arrangements had been made for her to meet a friend at home. This portion of the report examines how this happened and it explores a number of issues raised as a result of the practices in place at SOGH at the time. It also examines a number of steps WRHA and SOGH have taken to address these issues.

[309] Dana Brenan set up meetings at the hospital to get answers on her mother's care at SOGH and why she was sent home in the circumstance she was. Her first meeting was with Dr. de Faria on February 10, 2012. At that meeting, she thought Dr. de Faria was being quite straightforward with her. She was disappointed Dr. Dowhanik was not there, as she thought he would be, but she was advised it was not appropriate at that stage.

[310] Dr. de Faria said he did meet with Dana Brenan in his capacity as Chief Medical Officer for SOGH. At the time of the meeting, he did not have all of the facts of what happened. In his view, it is not always appropriate for a family member to meet with the treating doctor after a tragic event. This did not appear to be clearly articulated to Dana Brenan prior to the meeting. Very quickly this matter was escalated to the Regional level and Dr. de Faria had very little involvement from that time on. An Administrative Review and a Critical Incident Review was commenced.

[311] Dana Brenan said she asked for Heather Brenan's medical chart and she was denied access. Dr. de Faria was not clear on if that happened or why it would happen. Dana Brenan also said she was advised a Critical Incident Review would be held and the results would not be available until May or June. She was told she would not see a copy of the report, but she would be invited to a meeting where she could take notes as the report was discussed.

[312] Dana Brenan was clearly unhappy with how the communication with her was handled following the death of her mother. She felt she was not being provided information she was requesting and she said in her testimony she felt she

was being 'managed'. As a result, she went to the press and said she was being denied a copy of the report she was seeking. She said it was after she had done this the hospital told her she would get a copy.

[313] It became clear during Dana Brenan's testimony that she misunderstood what report she would be entitled to. She was entitled to the Medical Records and the Administrative Report (which is not a confidential document) and she did receive those. She would not, however be provided a copy of the Critical Incident Report, because it is confidential, as per legislation.

[314] The manner in which the communication between Dana Brenan and the WRHA unfolded led to mistrust and miscommunication on all sides. Given the difficult circumstances Dana Brenan found herself in, grieving the loss of her mother, her expectations of the process and the disclosure she sought, were higher than what the WRHA was able to provide, given the legislated limitations. Dana Brenan felt the process was not transparent and she said she remained confused as to what actually happened with her mother. For example, she was still not clear at the hearing why Heather Brenan did not get a bed. Was it because one was not available or because she was not assigned a bed? This confusion remained after she received the Administrative Review and after she was advised of the findings in the Critical Incident Review.

[315] One way to resolve this unfortunate situation of miscommunication, and misplaced expectations, may be the creation of a policy. The policy could clearly outline what information is available during the review of critical events and how the family concerns will be heard and how the family will be kept informed. This may resolve the issue of what information is available and when it will be available. It would create a more understandable and transparent process.

I therefore recommend*:*

The WRHA consider creating a policy, to be provided to families involved in critical events, explaining what information will, and will not, be made available and an explanation of how communication and meetings between the parties will be dealt with through the review process.

[316] On June 15, 2012, Dana Brenan and Ms. Northage met with Karen Dunlop - Program Director WRHA Emergency Program, Dr. Chochinov - Medical Director WRHA Emergency Program, and Lori Lamont -Vice President and Chief Nursing Officer WRHA (as of June 2012). On that day, the WRHA provided a de-brief of the Critical Incident Review, as well as the Administrative Review. On August 7,

2012, Dana Brenan was forwarded, by mail, a copy of the complete Administrative Review, including recommendations and the notes outlining the Critical Incident Review.

[317] Dr. Alecs Chochinov was involved in the reviews. Among his other accomplishments, Dr. Chochinov is an Emergency Physician, obtaining his Medical Degree at the University of Manitoba in 1979. He has a Specialty Certification in Emergency Medicine from the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada. He attended Harvard Medical School in 1990/91. He has historically been an Emergency Physician at St. Boniface Hospital and he continues to spend one third of his time there as a Clinical Emergency Physician. In 1994, he became the Clinical Director of the Emergency Program at St. Boniface Hospital and held that position until 2010. From 2010 to the present, he is the Regional Medical Director of the WRHA Emergency Program. He is also an Associate Professor at the University of Manitoba in the department of Emergency Medicine.

[318] Dr. Chochinov is often a presenter at various conferences on the topic of patient flow, particularly in the ED. He is an advocate of Nurse Practitioners and Physician Assistants in the ED. He is also an advocate of Hospitalists as part of the health care team.

[319] Dr. Chochinov explained: when an adverse event occurs, as it did here with Heather Brenan, the Medical Director at the hospital, where the event occurred, usually conducts an investigation. Each hospital within the WRHA has a Medical Director and Dr. de Faria is the Medical Director at SOGH. When the event is considered to have a broader implication, that is Regional implications, or if the event is thought to include a preventable death, he gets involved.

[320] Dr. Chochinov explained in this case, a Critical Incident Review and an Administrative Review were conducted. The Critical Incident Review, as mentioned above, is a legislated process; consultants are engaged and recommendations are made. The process is confidential and the results are not made public.

[321] Administrators within the program conduct an Administrative Review and the focus is on patient and clinical outcomes. The results are not protected by legislation.

[322] Dr. Chochinov, along with Karen Dunlop, the Program Director WRHA Emergency Program, were responsible for the Administrative Review of Heather Brenan. The Administrative Review was filed as an exhibit in these proceedings.

[323] Ms. Dunlop conducted the majority of the interviews and Dr. Chochinov met with Dr. Dowhanik, Dr. de Faria and Dana Brenan.

[324] Dr. Chochinov was responsible from a medical standard of care perspective. The two questions posed to him on the Administrative Review were:

1. Could Heather Brenan's death from pulmonary embolism have been prevented or suspected earlier?
2. Should Heather Brenan have been discharged from the hospital on January 27, given her overall medical condition? And was her functional status such that discharge was safe?

[325] Dr. Chochinov's responses to these questions will be highlighted in the applicable section of this report dealing with each issue.

[326] Dana Brenan's concerns were also clearly set out in the Administrative Review. They were listed as follows:

- she was not given an explanation as to why her mother was not admitted
- her communication with staff while Heather Brenan was at the hospital. At times the staff was friendly and accommodating and at other times rude
- she was not given a copy of her mother's health record
- she was not told why her mother was not fed
- she did not have an explanation as to why her mother was not given her medications while she was in hospital and specifically, why she was not given her blood thinner
- she questioned why her mother did not receive Home Care
- she wanted to know how the decision was made to send her mother home in a taxi, without the Emergency doctor examining her

- she wanted to know why her mother was sent home in a taxi without her keys
- she questioned whether her mother should have been sent home at all, as she did not feel her mother was stable enough to go home
- she was distressed at the confusion of the hospital staff when dealing with Ms. Northage and Ms. Thompson
- she was distressed; she was contacted by the Speech Language Pathologist at home regarding a swallowing test, after her mother passed away
- she was not permitted the opportunity to speak to the doctor who discharged her mother (Dr. Dowhanik) when she met with Dr. de Faria

[327] The Court heard, and clearly understood, the concerns raised by Dana Brenan and Heather Brenan's friends. Throughout these next sections, the Court will address those concerns and make recommendations where appropriate.

[328] The issues that were raised by Dana Brenan, and those dealt with in the Administrative Review generally, are inter-related. That Heather Brenan did not have a dedicated doctor looking after her care at such a busy time in the ED which created a number of these issues. It resulted in numerous health care providers being involved in her care and in numerous handoffs between these health care providers. Heather Brenan's chart was not well documented on several occasions; at times health care providers were not aware of who had seen her and what remained to be done; her chart was not comprehensively reviewed by all health care providers, rather many relied on the information that was passed on from the last health care provider looking after her. There was confusion among the nurses at SOGH as to whom they were speaking to at discharge. There were questions surrounding the completeness of her examination at discharge and in particular, whether an appropriate functional assessment was done.

A. Heather Brenan Was Not an Admitted Patient

[329] Hospital Policy at SOGH in January of 2012 was such, that if you were not admitted to a ward, you were not assigned a Family Physician.

[330] Understanding why there are not enough family doctors to admit patients from the ED, sheds some light on what happened to Heather Brenan.

[331] Dr. Chochinov provided general information on the working relationship between the WRHA and the doctors who work in ED. These doctors are not employees of the WRHA. He said the WRHA has contracts with the doctors to provide emergency services. At SOGH, there are a number of Family Physicians who have ward space to admit patients. Usually, he says, there is enough space to admit patients to the wards and SOGH has had very good metrics in this regard. However, he confirmed as others have, SOGH was in a bed crunch at the time Heather Brenan was at SOGH. There were not enough ward beds available for admission. As such, she remained 'boarded' in the ED and under the care of ED doctors.

[332] Dr. Chochinov explained that ED doctors do not take over comprehensive care of a patient. They are not familiar with all of their health issues like a family doctor is. The role of the Emergency Physician is to deal with the *acute problems*. When a patient presents to Emergency, one of the advantages, versus going through a Family Physician, or even being in a ward, is as a patient in the ED, you have access to diagnostic tests and specialists on a priority basis. Usually consults with specialists can be done within two hours. This enables the ED doctor to deal with the patient's acute issues in a much more timely manner.

[333] As Dr. de Faria explained, historically at SOGH, family doctors looked after patients in the ED who had been admitted. That changed over time and ED doctors were then not responsible for these patients until they were physically transferred to a ward. This was the case in January, 2012. Since January, 2012 this practice has changed again. Currently, once a patient is admitted, they become the responsibility of a family doctor and the family doctor looks after the patient, even if the patient remains physically in the ED. There are several benefits to this approach.

[334] One of the significant benefits is the patient now has consistency of care and there are fewer handovers and exchanges of information between doctors as a result. There is one doctor aware of all complaints, what tests and consults are ordered, what the results are and what the plan forward is. This one doctor will be familiar with the chart and they will be involved in all aspects of care. There is less reliance on information passed on from others because one doctor is coordinating the care. There is a central point of contact for the family and friends concerned about the patient. Further, it frees up the ED doctors to look after ED patients, rather than the admitted patient.

[335] Ms. Lamont addressed this issue. She was involved in the Administrative Review and she met with Dana Brenan. Ms. Lamont and the WRHA have

acknowledged this is an issue and it was an issue in Heather Brenan's case. The Court agrees. There is no doubt Heather Brenan's experience at SOGH would have been much better if she had been assigned a family doctor who was the primary person responsible for her care. This approach would have alleviated many of the concerns raised by Dana Brenan

[336] The first recommendation set out in the Administrative Review is:

> *All patients requiring stays in the ED, of greater than 24 hours, should be admitted to hospital under the care of a dedicated physician and placed in an inpatient bed. Each site must develop a process to comply with this directive, in order to increase accountability and patient safety.*

[337] The Court adopts the above recommendation as a recommendation in this report.

[338] Ms. Lamont confirmed this is now the case at SOGH. Ms. Lamont acknowledged this target is not met every day at every hospital across the Region, as flow and capacity issues continue to make it difficult. The target is to have this apply system wide.

I therefore recommend:

The WRHA continue to work towards a fully implemented Regional policy that all patients requiring stays in the ED of greater than 24 hours, should be admitted to hospital under the care of a dedicated physician and placed in an inpatient bed. Each site should develop a process to comply with this directive, in order to increase accountability and patient safety.

B. The Functional Assessment

[339] The Administrative Review stated the following:

> Mrs. Brenan's overall functional status was very compromised. Some of the factors which would have impaired her ability to mobilize independently at home included obesity, multiple medical co-morbidities, weight loss with attendant muscle atrophy and de-conditioning from a prolonged ER stay. This was a patient who required a complete functional assessment prior to discharge.

[340] As mentioned above, one of the questions Dr. Chochinov was tasked with answering in the Administrative Review was;

> Should she have been discharged from the hospital on January 27, given her overall medical condition? And was her functional status such that discharge was safe?

[341] In response to this, Dr. Chochinov stated in the Administrative Review, he felt Heather Brenan required "a more complete functional assessment including mobility and respiratory status prior to discharge and that did not happen". He testified he had spoken to Dr. Dowhanik, and Dr. Chochinov's recollection of that conversation was Dr. Dowhanik had seen Heather Brenan ambulatory without oxygen on at least two occasions prior to her discharge. Dr. Dowhanik advised Dr. Chochinov, in his view; he had performed a satisfactory functional assessment.

[342] Dr. Dowhanik was questioned about the nature of the functional assessment he performed on Heather Brenan prior to her discharge.

[343] Dr. Dowhanik said he disagreed with the comment in the Administrative Review that the Functional Assessment was insufficient. From his perspective, her functional status had been assessed by OT/PT on January 26. Heather Brenan did not experience any deterioration in her activities of daily living or her ability to mobilize. There did not seem to be a change in status and he considered the complete assessment to have been done; therefore, he did not see the need for another one. Dr. Dowhanik said OT/PT considered Heather Brenan to be at baseline. Even though she was on oxygen when the Functional Assessment was done, he understood they were satisfied, and did not need to see her again. Once she was medically stable from OT/PT perspective she could be discharged. He further testified that Heather Brenan was able to mobilize in Pod 3 and talk on the phone without oxygen before discharge so he was satisfied the Functional Assessment was satisfactory.

[344] Dr. Dowhanik said he relies on the nurses to advise him if there are any issues with respect to functionality. Mr. Anderson testified he did not do an actual assessment. Mr. Anderson's opinion of Heather Brenan's functionality was based on his observations of her. He saw her mobilize to the bathroom twice without her oxygen and with only a stand by assist. He said she raised no concerns, she did appear to out of breath and her walking was solid. Mr. Anderson acknowledged he was not aware of the OT/PT or Home Care notes in the file. Neither was Mr. Didkowski. Both were aware Dr. Dowhanik was assessing Heather Brenan and neither raised any concerns with respect to her status. Mr. Didkowski did

indicate that, if he had been aware of the Home Care note, he would have raised this with Dr. Dowhanik. No notes were entered by any of these caregivers in the Integrated Progress Notes about the Functional Assessment prior to Heather Brenan's discharge.

[345] Dr. de Faria also spoke to the completeness of the Functional Assessment. He explained if a person is admitted to a ward, or a patient is on a Rehabilitation ward, the Functional Assessment completed is fulsome. In those cases, OT/PT will examine all areas of a person's functioning, including whether they can cook at home; remember to turn off a stove, as well as ensuring the person is physically able to manage all tasks of daily living. These assessments would involve OT/PT assessments.

[346] Dr. de Faria said a Functional Assessment in the ED is performed at a different level. The consideration in the ED is: Can this person go home relatively safely? Can they ambulate? Get in and out of bed?

[347] Dr. Chochinov agreed in his testimony, a Functional Assessment in ED is different than one done for an inpatient on a ward. The inpatient has a Functional Assessment performed that could take up to half a day. He accepted this is not possible in the ED and agreed an abbreviated functional assessment in the ED is appropriate. However, he said in this case, it was difficult to determine the extent of the Functional Assessment of Heather Brenan because there was very little information recorded in her medical chart.

[348] Dr. Chochinov said that, while the doctor does not have to perform all of the elements of the Functional Assessment himself, and while it is appropriate to rely on a nurse to check oxygen saturation levels for example, he would expect this to be recorded in the chart. Dr. Chochinov said this was not recorded in the chart in this case, as it should have been.

[349] Dr. Chochinov advised there are no national standards for functional assessments performed in the ED. He said there is research ongoing that is looking at abbreviated functional assessment for the ED.

[350] Dr. Chochinov acknowledged in his testimony, that having reviewed the steps taken by the nurses and Dr. Dowhanik, with respect to the Functional Assessment, he was satisfied an appropriate ED Functional Assessment, including Oxygen Assessment, was completed. He remained concerned that none of this was captured in the Integrated Progress Notes. The Court shares this concern.

[351] There appeared to be different views between the nurses, Mr. Anderson and Mr. Didkowski on the one hand, and Dr. Dowhanik on the other hand, as to whose responsibility the Functional Assessment was. Ultimately, they all agreed the doctor is responsible to ensure the patient is functional, but the lines of responsibility for actually performing the examination appeared blurred.

[352] In this case, it does not appear oxygen saturation levels were taken for Heather Brenan prior to discharge. If they were, they were not recorded in the Integrated Progress Notes. Rather, it appears both nurses and Dr. Dowhanik relied on what they saw of Heather Brenan and her ability to mobilize without oxygen to form the opinion she was functional in this regard.

[353] Heather Brenan's oxygen saturation levels were addressed throughout the course of the hearing and several doctors were questioned about this issue. The concern was raised because; she appeared to be on oxygen throughout much of her stay; she desaturated during her gastroscopy procedure (which was the same day she was released); and she had difficulty breathing, which can be a sign of PE.

[354] The evidence did show Heather Brenan was on varying amounts of oxygen during her stay. Dr. Schneider said the amount of oxygen she was on was a low dosage of oxygen. The evidence also showed while Heather Brenan was not very mobile during the length of her stay, she was able to mobilize, get up and go to the bathroom, and back without oxygen at times. The evidence showed that notwithstanding her desaturation during her gastroscopy at the Victoria General Hospital, her oxygen levels stabilized to the point she could be transported back to SOGH. A number of possible reasons were given for her desaturation during this procedure, including the type of medications she was given, her weight, not being able to tolerate a scope being inserted into her esophagus and potentially the fact she had developed a PE. The evidence disclosed she was up without oxygen prior to her discharge. This is not to say she did not experience shortness of breath; the evidence also disclosed she did at various times during her stay. She clearly was having trouble breathing by the time she arrived home after she was discharged.

[355] This Court has no medical knowledge or experience and therefore makes no findings as to whether the assessment of Heather Brenan's oxygen level, at the time of discharge, was appropriate. What is of relevance here is the fact that no one recorded what her oxygen saturation levels were at the time of discharge. This concern is tied into the concern that there is no standard protocol for a Functional Assessment in the ED prior to discharge.

[356] The WRHA has addressed the issue of the Functional Assessment and consideration of the need to take vital signs prior to discharge in its Safe Discharge Guideline, which was implemented following this incident. This will be reviewed in the section on Safe Discharge.

[357] Dr. Chochinov also spoke to the need to mobilize patients in the ED, particularly when they are there for extended periods of time. He said this is supposed to be done for patients who remain longer than 24 hours and it is supposed to be done for patients on the wards as well. He said OT/PT are utilized for this reason. However, Dr. Chochinov stated it is "never optimally done."

[358] Given the length of time Heather Brenan was in the ED, she clearly would have benefitted from being mobilized more often than she was. This issue, and the need for an appropriate Functional Assessment in the ED, were addressed in the Administrative Review. Recommendations were made as follows:

- *The University of Manitoba, Department of Emergency Medicine should collaborate with the WRHA Emergency and Occupational Therapy Programs to develop standards of care for Functional Assessments or have a screening tool of vulnerable patients in the ED.*
- *All WRHA hospitals should work with the Regional Occupational Therapy Program to ensure nursing based Functional Assessments are performed with patient safety as the foremost consideration.*

[359] The Court adopts these recommendations as recommendations in this report.

[360] The Court also believes mobilization in the ED is important, particularly for patients who have lengthy stays.

I therefore recommend:

The WRHA consider designing and implementing a program on a Regional level, involving OT/PT, to ensure patients in the ED who remain longer than 24 hours, are mobilized regularly wherever possible.

C. Home Care

[361] As we know, Home Care had seen Heather Brenan. They did not do a full assessment at the time because they did not feel she was ready for discharge. Home Care had left a note on the file indicating they would see her before discharge. Home Care's understanding was Heather Brenan was looking for some

help at home with housekeeping, etc. Home Care did not have the sense Heather Brenan was in need of essential services, unless she was going to be sent home with a catheter or on oxygen.

[362] Neither of the nurses, on duty the night Heather Brenan was discharged, were aware of the Home Care note indicating she should be seen before discharge. Had they been aware, they would have brought this to the attention of Dr. Dowhanik. Dr. Dowhanik believes he knew Home Care had seen her, but he was unaware they wanted to see her before discharge.

[363] Dana Brenan and Ms. Northage were concerned Heather Brenan was sent home without the benefit of Home Care in place. The suggestion made is this was another example of Heather Brenan being released before all appropriate measures for her care were in place.

[364] The evidence does indicate Home Care did not complete its assessment. Heather Brenan should have had the benefit of that assessment once she ready for discharge. The facts show:

- Patients in the ED are sometimes "held" pending Home Care Services;
- Heather Brenan would only have been considered to be in the category of someone requiring essential services if she went home with a catheter or on oxygen. Neither of these steps was necessary in her case;
- Heather Brenan herself was requesting home assistance for housecleaning, and perhaps meal preparation. These services can be arranged in the community after discharge.

[365] Based on the evidence, even if Dr. Dowhanik had been aware of the note and had contacted Home Care, it is unlikely it would have changed Heather Brenan's discharge plan. The services she required would have been arranged in the community and not in the hospital.

[366] The manner in which Home Care operated in January, 2012, did raise a general concern for the Court. That is, when Heather Brenan was ready for discharge, on a Friday night at 10:30 p.m. or so, it was outside the hours Home Care operated. In fact, had Heather Brenan required essential services, there would not have been a Home Care worker at SOGH in the ED until Monday morning. Ms. Lamont explained in her testimony, the hours Home Care works, is set out in a number of collective agreements.

[367] The Sinclair Report addresses this issue and recommended:

> *That the RHAs review the feasibility of a seven-day workweek for the office of the Home Care Coordinator.*

[368] The Court supports this recommendation.

[369] Ms. Bergal advised in her evidence, steps have been taken to address other Home Care issues. Her understanding was in 2012 a patient, who needed essential and other services from Home Care, would be 'held' at the hospital until all these services are arranged. That clearly creates a block in the system. Now, in 2015, once the essential services have been arranged, the patient is discharged and the remaining services are arranged in the community. This would seem to be a better practice, as it limits the amount of time people have to wait in hospital for the Home Care service. Other witnesses testified that at SOGH, the practice was only to hold patients for essential services. Ms. Bergal conceded her understanding was different than some of the other witnesses, and she said it may be at SOGH patients were only held if essential services were needed, as that may be consistent with the internal process improvements SOGH had made prior to 2012.

[370] While the evidence is not clear on what the practice was in 2012, what is clear is the practice of holding patients only for essential services is more consistent with reducing blockages in the emergency room. The Court supports the application of this practice throughout the Regions.

[371] Ms. Bergal also recommended the role of the Home Care Case Coordinators in the community should be enhanced to ensure that, once services are provided in the community, the patient is functioning well. She felt the Case Coordinators have such a heavy caseload; they are not well positioned to assist fully in this regard. She said the Case Coordinator/Client Ratio needed to be adjusted to allow the Case Coordinators more opportunity to assist in the community. This would reduce the number of people who attend at the ED because their ongoing needs are not being met. In addition, Ms. Bergal felt the role of the Professional Nurse in the community could be enhanced again to assess how a client in the community is performing and functioning. In conjunction with the Case Coordinators, she felt this would create a richer model of Home Care.

I therefore recommend:

The WRHA consider the feasibility of developing a model where: the role of Home Care Coordinators and Professional Nurses in the community is enhanced; that clients performance and functionality in the community is monitored; and if

necessary, the type of care they are receiving in the community is enhanced, to avoid these clients from returning to the ED.

[372] Ms. Bergal also spoke to the fact that Home Care and the Allied Health Care Workers do not work in the hospitals on weekends. She pointed out discharges drop on weekends.

I therefore recommend:

The WRHA continue working to enhance the services of Home Care and Allied Health Workers to include staffing on weekends.

[373] A further concern for the Court, in considering the Home Care issue, is the fact that Dr. Dowhanik and the nurses on shift the night Heather Brenan was discharged were unaware of the fact Home Care wanted to see Heather Brenan before discharge. This speaks to a larger issue that was prevalent throughout Heather Brenan's stay and that is: a lack of clear communication among health care providers, both in terms of their written and oral communications. This issue will be examined next.

D. Communication, Charting And Note Taking

[374] Numerous examples were given at the hearing where information was not recorded in Heather Brenan's chart. Similarly, it was evident that generally information, about patients in the ED, is communicated orally from doctor to doctor and nurse to nurse, particularly at handover. Rarely does a doctor in the ED review an entire chart. The details of how doctors, nurses and Allied Health Care workers communicated and received information are contained in this report in the section on Heather Brenan's Course of Treatment at SOGH.

[375] This oral method of communication may be very effective and necessary for those patients who only remain in the ED for a short time. It is accepted that doctors and nurses in the ED are extremely busy and January, 2012, was an exceptionally busy time. However, in a case such as this, where Heather Brenan remained in the ED for an extended period of time, this method of communication appears to be less effective in providing all of the information to the many providers of the Health Care services necessary to the care for a patient. Several examples speak to how information was communicated and whether it was charted, in this case:

- Dr. Whyte confirmed that he did not enter any notes when he saw Heather Brenan on January 24. He testified that entering notes is

the job of the Physician's Assistant and he generally relies on them to do so. He explained that ED doctors do not generally have time to both enter notes and look after the patients. He further testified that nurses and Allied Health Care workers would usually enter notes on the chart.

- Dr. Schneider confirmed he made no notes in Heather Brenan's chart on January 25 or 26, while she was under his care. It should be noted there was a Physician's Assistant on duty during both of these shifts. Dr. Schneider said it is his practice to make notes, but he believes because of the how busy the ED was and because of the acuity of patients in the ED during that time, he did not make notes. He said that he usually makes a point of making notes particularly when there is a discussion with a specialist, or a change in management or some similar information, which should be recorded.

- Dr. Swirsky testified the only note he made in Heather Brenan's chart on January 26, 2012, was regarding the consult he wrote to the Neurologist, Dr. Eggerston. He said he did not document his second interaction with Heather Brenan and he did not advise her, or her friend Ms. Northage, of the change in her status from admitted to hold.

- Dr. Swirsky said he did not discuss with Heather Brenan the use of an anticoagulant Heparin, or otherwise, and agreed that ideally, it was a conversation one should have with the patient so they can make an informed decision. He could not say if his lack of documentation was because he was too busy. He did agree there was no excuse for the lack of documentation and stated there should be clear documentation of the treatment plan and all issues surrounding it.

- With respect to chart review, Dr. Swirsky did explain the competing interests of patient care in Emergency and chart review. He stated that theoretically, every word in a chart should be reviewed but in practical terms, there is just not enough time to do so. He said the reality is, you have a certain amount of time to apportion per patient and it depends on the patients needs. You rely on your colleagues at the time of sign over, as well as the

nurses and professional staff who are looking after the patient, to share any pertinent information.

- Dr. Swirsky also spoke of the challenges that arise when a patient is kept in Emergency for an extended period of time, as Heather Brenan was. He said the doctors in Emergency change three times a day and this is a concern because literature has shown it can be associated with negative outcomes.

- Ms. Egefz transported Heather Brenan to Victoria General Hospital on January 27. She assessed her prior to leaving SOGH and found her satisfactory to transport. She did not chart her assessment prior to leaving, although she said this is usually done.

- Ms. Knockaert testified she was the Charge Nurse from 3:30 to 7:45 p.m. on January 27. She had taken report from the outgoing Charge Nurse and was not entirely satisfied with the report. She said she would like to have had a better report on the reasons Heather Brenan was in the ED, particularly given the length of time she was there.

- Mr. Anderson indicates he does not chart unless something was unusual. He relies on what the outgoing nurse tells him. He was not aware of OT/PT or Home Care consults and would have reassessed had he known. He did not assess Heather Brenan himself as he felt the outgoing Bedside Nurse had done so and he relied on his own observations.

- The Court notes this means there would have been at least 3 Charge Nurses dealing with Heather Brenan on January 27, the day of her discharge. One prior to 3:30 p.m., one at 3:30 p.m. and one at 7:45 p.m. None of the communication among the Charge Nurses appeared to be fulsome, as is indicted by Ms. Knochaert's concern; she would have liked a more detailed report.

- Dr. Micflickier provided an oral report to the Transport Nurse regarding Heather Brenan's desaturation. He also sent a report that said she had trouble tolerating the procedure. This report did not include a note that her oxygen level had dropped to 75%. He had

dictated a report to be sent on a rush basis but this report did not reach SOGH before Heather Brenan was discharged.

- The evidence disclosed Dr. Dowhanik and Dr. Mikfickier did not actually speak to one another after the gastroscopy and prior to Heather Brenan's discharge. Dr. Mikflicker indicated he tried to pass the message of Heather Brenan's desaturation to SOGH ED through his notes and the Transport Nurse, but his concern about her condition was not communicated clearly. Dr. Dowhanik said he tried to page Dr. Mikflicker but Dr. Mikflicker denied receiving a page. While the Court cannot reconcile the paging issue, it is clear the communication was lacking.

[376] With respect to handovers, there appeared to be a consensus these should be limited. Given her length of stay, Heather Brenan went through a number of handovers.

[377] The doctors who testified, consistently said it is their practice at handover, to write their own short notes about each patient. These notes are kept for their personal use and they do not make their way to the chart. Once the shift is over, the doctors dispose of the notes. The information in the notes usually contains the patient's name, and the pertinent information they received at sign over, consultations, the plan forward, etc. The nurses who testified said they also keep a 'cheat sheet' with this type of information and again, it is discarded at the end of a shift.

[378] Dr. de Faria spoke to some of these communication issues. He said there are daily huddles in the ED and a Charge Nurse, doctor and OT/PT or other caregivers, may attend. These huddles discuss particular patients and those who may be able to be moved, depending on the patient's situation. He said these huddles are usually quite short.

[379] He also spoke about a Safe Hand Off Tool. This is a tool that has been developed for patients who are transferred from the ED to a ward. The intent of the document is to communicate clearly between departments the relevant information about a patient. This form is not used in the ED for hand offs between nurses or doctors.

[380] Dr. De Faria also described a 'Flight Board', which is a communication tool used for patients who are admitted to a ward. The Flight Board indicates where a

patient is in terms of consultations, etc. For example, the Flight Board visually demonstrates if OT is complete with a green dot. If PT is outstanding, it has a red dot. This gives hospital staff a clear indication of what has been complete and what is yet to be done. It helps move patients through the hospital because if they are waiting on one consultation, for example, before they can be discharged. That consultation will become the priority for the day. This is not available in the ED.

[381] It was suggested by one of the nurses that a form, containing similar information to that in the Safe Hand Off Tool, be developed for use in the ED. Dr. de Faria was asked about the usefulness of such a form. He said that, among the doctors, nurses and Allied Care personnel, there is communication. He questioned the utility of creating another forum to communicate the same information; keeping in mind the goal is not to have patients in the ED for a length of time where these types of tools would be necessary.

[382] The Court acknowledges Dr. de Faria's concern of having numerous places doctors and nurses have to enter information. The Court also acknowledges the goal of not having patients remain in the ED for such a length of time, so that this is necessary. However, the evidence in this case demonstrated there were many handovers and a lack of communication. Further, the evidence has shown the WRHA hospitals are struggling to meet their goals for how long patients are in the ED before being treated.

[383] Dr. de Faria did suggest something could be developed which would highlight what is outstanding with a patient. He thought it might be possible to build this into the EDIS electronic record at the next upgrade of the computer system, so that any caregiver to the patient could have a map of where the patient is. Currently SOGH has the ability to track patients and all their information on EDIS and they also have clinical records on EDIS.

[384] Ms. Lamont also spoke of the importance of involving family and the patients as part of the health care team. She said that as part of the collaborative care effort, communication about a patient should take place bedside, particularly at handover, so the family and patient are fully informed and can be part of the conversation and discussion. This approach would be relatively new to health care and it would mean a change in hospital culture, as well as education to implement such an approach.

[385] A tool which would allow a current map of the patients care, and which could easily be accessed by doctors, nurses and Allied Health workers, would aid

communication in the ED; this tool would provide up-to-date accurate information about patients and their status to health care providers which would be beneficial to patient care.

[386] The Administrative Review made two recommendations in this regard as follows:

- *The WRHA Emergency Program Guidelines for Safe Hand Off (May 2012) be implemented at all WRHA ED sites to ensure complete, safe and accurate exchange of information at handoff.*

- *The WRHA Emergency Program Guidelines for Safe Hand Offs be used as a template for developing a similar set of expectations and practice tools for handoff between sites*.

[387] The Court adopts these recommendations as recommendations in this report.

[388] The Court also sees value in a Safe Hand Off Tool for the ED, as well as conducting handover at bedside in the ED.

I therefore recommend:

The WRHA consider creating a Safe Hand Off tool to be used in all EDs for patients remaining longer than 24 hours. The Safe Hand Off tool would be used at handover by all nurses and doctors involved in the patient's care.

The WRHA continue to pursue education and culture change within the WRHA with the objective of including the patient and families in discussion of the patient status and treatment, including performing handovers at bedside.

[389] The Administrative Review Team also made a number of recommendations related to documentation and communication. Some of the recommendations that will assist with these issues are contained in the next section and relate to the Safe Discharge Guidelines. The other recommendations, are listed below and referenced by the number they are listed in the Administrative Review:

> *9. Documentation practice be specifically targeted for improvement through continuing education for current staff and also increased in the general orientation program for new ED nurses*.

10. The Emergency Program review and reinforce the need to report on all pertinent information including any specific adverse reactions or experiences and that these are properly documented and communicated by physicians and nurses giving or receiving report on a patient at hand off.

[390] The Court adopts these recommendations as recommendations in this report.

E. Safe Discharge

[391] Both Dana Brenan and the Administrative Review noted Heather Brenan was sent home late at night, in cold winter weather, and in a taxi. Further, both noted that the communication between Heather Brenan's friends and SOGH was at best, confusing. The details are set out above in the section Heather Brenan's Course of Treatment at SOGH. The evidence disclosed SOGH policy was such that it would not release a patient unless it was safe to do. However, SOGH did not have a formal discharge policy in January, 2012.

[392] Dr. de Faria spoke to a Safe Discharge form that existed prior to this incident, which he had created to encourage patients to raise concerns prior to discharge. It is a one page document which had been placed around the hospital but did not have the uptake he had hoped for. This document essentially tells a patient to raise any safety concerns he/she has and it advises the patient to understand the signs and symptoms that would require them to return to the ED.

[393] In specific response to what happened to Heather Brenan, and because of other similar cases, in March, 2012, the WRHA took a number of steps. One of those steps was to develop and implement Interim Guidelines for all EDs for 'late night discharge' of vulnerable patients. The WRHA sought consultation and feedback from the Patient and Family Advisory Council on these guidelines, and incorporated the feedback into the final Guideline.

[394] The WRHA finalized the Safe Discharge Guideline and implemented it across the Region. The stated purpose of the Guideline is: "To provide guidelines to optimize post-discharge safety for adults who present and are discharged from emergency departments 24 hours a day, 7 days per week." A vulnerable person is someone with increased susceptibility to risk due to cognitive, emotional or physical limitations. The Guideline is a 4 page detailed document which, among other information, states: who it should be used by, the guiding principles, the guideline itself - including who makes the decision to discharge, what to consider when discharging vulnerable patients, the need for a written order of discharge

from a doctor indicating the doctor has considered all available tests and diagnostics, that the patient can manage at home, that the patient has been thoroughly assessed, that vital signs have been taken within an hour of discharge and that all information has been documented in the Integrated Progress Notes.

[395] The WRHA also developed a Patient Discharge Checklist, which is a document intended to capture much of the information considered in the Safe Discharge Guideline. This has also been implemented at all adult emergency departments and Misericordia Acute Care centre.

[396] The WRHA also implemented a Safe Transportation Guideline. This again is a very detailed document, which addresses taxi service home for eligible patients who require assistance. It describes the level of service recognizing some patients need assistance directly into their residence. It involves the Manitoba Taxicab Board and, the Winnipeg Fire Paramedic Service Inter-facility Dispatch. It spells out the documentation necessary to comply with the guideline and it incorporates a feedback mechanism to the hospitals to ensure patients arrive home safely.

[397] The WRHA also did research to see if it could determine if there was a particular trend around evening discharges that would provide additional information. The data did not reveal any information of significance in terms of issues with late night discharge.

[398] The WRHA also did an analysis of all Critical Incidents in the WRHA EDs over the past 5 years, searching for trends/issues in patient flow, overcrowding and hand off's. Noting the limitation of the research because the database used recorded narrative information, the conclusion was communication issues are the biggest single issue correlated with Critical Incidents in the ED. Communication in this context included: communication with external entities, such as communication between EDs and PCHs, Public Health, other hospitals, as well as with inpatient wards, labs, consults, advance care planning and documentation (charting).

[399] It is clear the WRHA has considered these issues seriously and it has taken action to resolve these issues. The Administrative Review made a number of recommendations as follows:

> 5. *The WRHA Emergency Program Guideline for Safe Discharge be implemented beginning May 21, 2012, to provide better guidance for discharge planning.*

> *8. Senior Management and Emergency Leadership, at all sites, should be of the need to maintain a culture of patient safety in their EDs; regardless of the pressure to maintain patient flow. To this end, Physicians are encouraged to discharge patients only when it is safe and reasonable to do so. To that end, the Guidelines for Safe Discharge, that have now been implemented across all sites, should assist both Physicians and Nurses in ensuring the discharge plan developed for each patient is both appropriate and safe. Nursing and other staff, should be encouraged to make any patient related concerns known to the Physician, so that they can act as a check and balance for the Physician.*

[400] The Court adopts these recommendations as recommendations in this report.

[401] Given the amount of work and effort the WRHA has done in this regard and given the implementation of Safe Discharge Guidelines, Safe Transportation Guidelines and the Patient Discharge Checklist, the Court has no further recommendations in this regard.

F. The Quality of Communication Between Heather Brenan's Friends and SOGH on Discharge and The Communication With Dana Brenan and SOGH

[402] As is detailed above, in the section on Heather Brenan's Treatment at SOGH, it is clear; the nurses at SOGH did not understand specifically whom they were speaking to the night of her discharge. Similarly, because two male nurses were involved, Heather Brenan's friends did not realize they were speaking to different people at SOGH.

[403] This was clearly upsetting for Ms. Thompson and Ms. Northage. It leaves an impression of disorganization, which is not helpful to family and friends who are concerned about the patient.

[404] Dana Brenan also thought the doctors and nurses were not sensitive to a grieving family.

[405] The WRHA has addressed some of these issues in its Safe Patient Checklist. The Checklist requires the hospital staff to document if they speak to family or friends and record specifically who that person is.

[406] The suggestion was made that compliance with these checklists be formally audited. Ms. Lamont was reluctant to agree that a formal audit would be necessary. She said her preference would be to have staff conduct their own audits

periodically, as part of continuous improvement and quality assurance. She said even this form of auditing would be difficult to do in an ED setting.

[407] The Court finds there is some value in ensuring the policies and guidelines are complied with.

I therefore recommend:

The WRHA consider the feasibility of periodically determining the level of compliance the Guildlines for Safe Hand Off, Safe Discharge Guideline, the Safe Transportation Guideline and the Safe Patient Checklist, and that it seek ways to continually improve compliance.

[408] The Court also endorses the recommendation made in the Administrative Review as follows:

> *11. The WRHA Emergency Program Leadership work with site Emergency Departments to improve communication between staff and patients and their families, being sensitive to the stress experienced by patients during an emergency visit.*

[409] With respect to Dana Brenan's concerns, the hospital staff were not sensitive to the needs of a grieving family, the Court notes Dr. de Faria's evidence that hospital staff are trained in this area.

[410] It would appear this training is limited and occurs fairly early in a Health Care Practitioner's career. It would be worthwhile for all health care providers to continue education in this area, but the Court does not feel it is necessary to make a specific recommendation in this regard.

G. Other Concerns

[411] Dana Brenan and Ms. Northage expressed a concern that Heather Brenan was not fed at SOGH and her overall nourishment was not considered. Ms. Northage testified she felt Heather Brenan was discriminated against because of her weight. The Court does not find this to be the case.

[412] A number of doctors did order nutritional supplements for Heather Brenan. In addition, Heather Brenan was assessed by a Speech Language Pathologist to determine the appropriate consistency of diet.

[413] Heather Brenan was on a NOP (not per oral diet) for much of her stay at SOGH, because of the investigation of her complaints and because of the planned gastroscopy.

[414] When she was discharged, a supplement was recommended and Heather Brenan was comfortable with that order.

[415] Dana Brenan was upset she was contacted by the Speech Language Pathologist after Heather Brenan's death. This was unfortunate. It would have been preferable for the SOGH to advise the Speech Language Pathologist, and any other health care providers who planned to follow up with Heather Brenan in the community, of her death. This would have saved Dana Brenan the anguish of dealing with this issue.

XI. Cause of Death

[416] Concerns were raised by Dana Brenan as to the cause of Heather Brenan's death and whether it was preventable. Specifically, she was concerned the doctors treating Heather Brenan should have been alert to the possibility of DVTs and PEs. Dana Brenan felt the doctors could have predicted Heather Brenan was at risk, given a number of health indicators present. Further, Dana Brenan felt the issue of DVTs could have been treated at SOGH, whether with anti-coagulants or some other form of treatment. The Court heard a great deal of evidence on these points. In this section of the report, the Court will examine the cause of death and the evidence with respect to DVTs. The Court will also review the evidence of whether the doctors, who cared for Heather Brenan, felt her death was preventable.

[417] Dr. Susan Phillips testified as an expert witness in Pathology. Among her other professional qualifications, she is a Medical Examiner and Pathologist for the Province of Manitoba and an Associate Professor with the Department of Pathology at the University of Manitoba. Dr. Phillips conducted the autopsy on Heather Brenan.

[418] Dr. Phillips was the Medical Examiner on call when Heather Brenan passed. She received a Preliminary Report of Death, which is a summary report of the Medical Examiner investigation. She also received the Medical Records from SOGH the day after she completed the autopsy. Dr. Phillips completed a Preliminary Autopsy Report following the autopsy performed on January 31, 2012. It outlines, among other information, the Pathologists pertinent findings and preliminary cause of death. As Dr. Phillips said, the results might change in the

Final Autopsy Report based on the completion of tests done at the autopsy and different consultations.

[419] Dr. Phillips walked the Court through her findings on autopsy. The immediate cause of death was bilateral pulmonary thromboemboli due to deep vein thrombosis of the lower legs.

[420] Dr. Phillips explained, although there were other findings she made with respect to other organs, she did not believe these other findings contributed to the cause of death.

[421] Specifically, she explained DVT is abnormal clotting of the blood within the veins, most often in the lower legs or in the legs generally. It can be caused by damage to the vessel wall, poor blood circulation and the blood hypercaoguating, or the blood increasing the ability to clot. One or more of these factors play a part in forming DVT.

[422] In Heather Brenan's case, there were clots in the veins of both calves and the clots appeared recent, although there was at least one clot that was older. By 'recent', Dr. Phillips explained they were not adhered to a vessel wall but were loose within a vessel. Dr. Phillips said the clots could have formed within several days prior to Heather Brenan passing away, but she could not say with certainty as to when they formed. With respect to the older clot, she said there was probably a DVT in the remote past and some of it may have shot into Heather Brenan's lungs but did not cause any symptoms. The large clot eventually degenerated and it ended up as a scar.

[423] Dr. Phillips explained that blood clots will travel through the bloodstream and they can lodge in an artery causing a PE. That is what happened in Heather Brenan's case. A large clot travelled through her bloodstream and lodged in her hilum, the biggest vessel in the right side right her lung. It would have obstructed most, if not all, of the blood flow to the right lung. This clot came from Heather Brenan's legs, according to Dr. Phillips, and had formed fairly recently.

[424] Dr. Phillips said an embolus that large was going to be immediately symptomatic, if not fatal and would not have been there for long.

[425] Dr. Phillips explained this large pulmonary embolus would have put an immediate strain on the right side of the heart and it would have cut off blood flow to the right lung. The left lung is left trying to oxygenate all of the blood causing hypoxia. The right heart strain and the hypoxia would have caused cardiac arrest

and collapse very quickly, within a matter of seconds to minutes. Dr. Phillips said this could have happened as Heather Brenan walked to her doorstep.

[426] The clot would have remained in her pulmonary artery and would have caused ongoing difficulty in her heart functioning and oxygenating the blood; including at the time she was being resuscitated. In addition to this major clot, Dr. Phillips found other clots within the lungs that probably travelled there before the large one. By 'before', Dr. Phillips said it could have been before Heather Brenan was hospitalized or during her hospital stay.

[427] Some of the other findings observed by Dr. Phillips, but which did not contribute to her death included:

- An enlarged heart, with evidence of hypertrophy in the myocardial muscle cells indicating a chronic strain, which was probably hypertension, related;
- Her esophagus showed an abnormal shape and showed severe non-specific chronic inflammation which is consistent with Heather Brenan's history of severe esophagitis;
- Chronic renal inflammatory changes and renal stones;
- Inflammatory infiltration on the thyroid;
- Multiple bruises on the limbs and the scalp and on the back of the shoulder

[428] Dr. Phillips did find some pigmentary changes of the lower leg and feet that are an indication of poor blood circulation. This was a chronic condition and would not have indicated a concern of DVT. Dr. Phillips also commented that Heather Brenan's arterial fibrillation may have made management of her care more difficult in her final hours and this was not related, in an obvious way, to her cause of death.

[429] Dr. Phillips said in her report:

> ...risk factors in this case for deep vein thrombosis and, thus the pulmonary embolus, included morbid obesity and recent hospitalization or inactivity, and possible recent dehydration due to her esophagitis and poor oral intake.

[430] Dr. Phillips expanded on the above to say there are a number of risk factors that can apply including dehydration, which would not normally be considered a factor. She said people known to have DVTs are advised to stay hydrated. Medical personnel looking after a patient can consider all of these factors but she could not say whether they would raise their suspicions of DVT. That she said is a medical question.

XII. Deep Vein Thrombosis (DVT)

[431] Almost every doctor who testified was asked about DVTs, PEs, their knowledge and experience in treating these, Heather Brenan's risk factors and what options each doctor may have considered in treating DVTs. They were asked specifically about the fact Heather Brenan was taken off the anticoagulant she was taking for arterial fibrillation and whether they would have considered Heparin as an alternative in her circumstance.

[432] Generally, all of the doctors were consistent in their evidence. The Court will not repeat all of the evidence of all of the doctors on this point. It will suffice to repeat the evidence of some of the doctors.

[433] Dr. Whyte testified he is aware of DVTs. He described them as a clot, usually developing above the knee, which can break off and can a PE. He is aware Heparin can be used to treat DVTs in appropriate circumstances.

[434] Dr. Whyte was asked about a number of risk factors of DVTs that may have applied to Heather Brenan. He agreed prolonged bed rest, being overweight and heart failure were factors. He said that factors such as kidney disease, being over age 60 are factors, but minor factors. He agreed it is better to prevent a DVT than to treat it once it's formed, but he cautioned that one has to be aware of the risk factors in administering a medication to prevent a DVT. He also said he was aware of a number of available treatments for DVTs once they form, including the use of circulatory stockings. He was not aware Heather Brenan owned a specialized pair of these stockings (due to her weight), post her knee surgeries. He also testified SOGH did not have a protocol or policy respecting the prevention of DVTs in January, 2012.

[435] Dr. Schneider was also questioned on the symptoms of DVTs and ways to prevent them. He was asked about the effect of mobility on the formation of DVTs. He said that although immobility can be a risk factor - he would not

consider Heather Brenan to have been immobile prior to coming into the hospital because she was functioning in the community. In his view, when thinking of 'immobility' as it affects a patients risk for DVTs, he is considering a patient who has had a stroke or is in ICU. Those he says are high-risk patients for DVTs.

[436] Dr. Schneider testified the use of anticoagulants in a patient like Heather Brenan is risky. Although she was on an anticoagulant for arterial fibrillation in the community, it was not prescribed to her to address a PE. While in the hospital, although he agreed she could be at risk, as everyone who is immobile is to some degree, he did not look for DVT specifically because Heather Brenan had none of the usual symptoms. Specifically he said she was not a surgical patient, or a stroke or ICU patient. He said she did not have any of the obvious risk factors. If she had complained of a big sore swollen leg, he would have been alerted. If she complained of chest pain, shortness of breath as an entrance complaint, that may have alerted him. He said in the course of examining Heather Brenan, because she was given fluids, the health care providers would be concerned about pulmonary edema, and they look for signs of that, including listening to her lungs, and checking for fluid build-up in her body, including her legs. If she had a swollen leg, they would have picked up on that.

[437] With respect to the risk/reward of prescribing an anticoagulant while in hospital, Dr. Schneider said that given Heather Brenan's anemia, her low platelets, an undiagnosed swallowing problem, she could have had a peptic ulcer disease. The risk of an anticoagulant would have been bleeding and he doubts any Physician would have prescribed an anticoagulant in those circumstances. He said he would not have prescribed it for her even if he had considered the use of Heparin generally.

[438] Dr. Schneider was asked specifically if Heather Brenan's chances of surviving would have been better if she had remained in the hospital, so that if she had the cardiac arrest in the ED, would they have been better able to save her. His response was telling. He said that a blood clot - that big - the size of the one that caused Heather Brenan's cardiac arrest is a terrible disease. And it is difficult to treat. He said they would have had to give her Thrombolytic - a clot buster - not a blood thinner, to bust up a clot that size and that is a very dangerous drug reserved for special cases. Dr. Schneider said giving it would have been a desperate attempt and it is not well studied. It would essentially be given on the speculation the cardiac arrest was caused by a PE. He does not believe many doctors would do that and in fact, he points out it did not occur here. Neither in Emergency, nor in the ICU, was it considered appropriate. Dr. Schneider's view is, even if

Heather Brenan had the cardiac arrest in the ED, and she had CPR right way, she may have been stabilized, but she would have succumbed to the PE shortly afterwards, He did not believe staying in the ED would have made a difference to her survival.

[439] Dr. de Faria also testified about the use of Heparin at SOGH in 2012. He said, at that time, it would have been used in the ICU and post surgery. It was not generally being considered on a ward for admitted patients or in the ED at that time. Since Heather Brenan's death, SOGH has instituted a protocol so that DVT prophylaxis is considered for all *admitted* patients. The use remains a medical decision and it does not have to be prescribed, but there is a computerized order sheet and it prompts the doctor to consider if it should be used. Dr. de Faria is monitoring compliance with the protocol and he said it is being considered in 78% of cases.

[440] Dr. de Faria said the application of a similar protocol in the ED is being considered for patients who are there a long time. He said there is no research on the use of DVT prophylaxis in ED and this has to be developed.

[441] Dr. Chochinov also addressed this issue. He said that all doctors, including ED doctors, would consider the risk of DVTs in their patients. He stated that in Heather Brenan's case, given her presenting complaints, the risk of DVT would not be high on the list. Further, the idea of anticoagulation would have to be balanced against the risks, and he felt she had a number of very significant risk factors. Had she been admitted, there is a protocol to consider administering Heparin, and he did not believe she would have been a candidate even then. Dr. Chochinov stated she would have been at risk for gastrointestinal bleeding and because of her renal failure, anticoagulants were contra indicated.

[442] Dr. Chochinov also said that in patients in the ED, the research to support the use of Heparin is not well established. There have been ongoing attempts to research this issue but there are no clear answers at this time. He said in time, it is hoped that evidence based protocols may be established to address this issue for patients who are not admitted, but who are in the ED for an extended period of time.

[443] The Administrative Review recognized the importance of pursuing this issue and it made the following recommendation:

> 2. *Patients requiring stays in the ED, of greater than 24 hours, should be considered for prophylactic Heparin. Evidence based protocols should be developed to this end.*

[444] The Court adopts this recommendation as a recommendation in this report.

[445] Dr. de Faria was asked if, in his opinion, Heather Brenan's death was preventable. His response was as follows:

> No. Where she dies - yes. How, what she died of, the answer is no. The whole issue is that she was going to die whether she had stayed in emergency department, whether she had been in a bed upstairs or whether she had walked home, or if she had gone home half an hour earlier, she still would have died. The death and the discharge are in no way related. And its, but it's still sad. Now, was it preventable? Many years earlier, maybe through health changes, but unlikely. I mean, this lady developed the early DVTs already on Dabigatran, which is a blood thinner. Although at the time, it wasn't aimed at stopping DVTs, it should have decreased them. This is not a preventable death. But what is preventable, and I think we sort of missed the point of what the tragedy in this. It's not that she died. She was going to die one way or the other, but the last three days of her life, of her conscious life, were in the emergency department lying on a stretcher and those are things that are sad for her.

XIII. Conclusion

[446] Based on the evidence the Court heard, it is clear all of the doctors responsible for Heather Brenan's care, felt her death was unpredictable, given her presenting complaints and her condition while at SOGH. They also agree her death was inevitable, given the massive PE that occurred. Moreover, they were united in their view that anticoagulants were contra indicated for Heather Brenan, given her condition and the gastroscopy she was to undergo at the Victoria General Hospital. The Court accepts, based on the evidence presented and the opinions of the doctors, this was not a preventable death. However, should be preventable is the length of time Heather Brenan spent in the ED, without being admitted to a ward, and the number of health care providers she saw.

[447] The fact that Heather Brenan's death was not preventable does not mean Heather Brenan's death was not a tragedy. Dana Brenan and Heather Brenan's friends raised a number of valid concerns regarding the circumstances surrounding her death. The Court hopes it has addressed these concerns throughout this report.

[448] Importantly, the WRHA has taken a number of steps to address the issues of admission, length of time remaining in the ED without a dedicated Physician, better management of handovers, more complete charting, better guidance for functional assessments in the ED, and a protocol for safe discharges for elderly and vulnerable people. Heather Brenan is responsible for many of these changes. Her experience at SOGH, and the circumstances of her treatment and discharge, has resulted in a number of positive changes in policies and protocols which will benefit other people going forward.

Dated at the City of Winnipeg, in Manitoba, this 22nd day of December, 2015.

Original Signed By

Judge Margaret Wiebe

XIV. Recommendations

- The WRHA should consider implementing a flag within its Utilization System so that any patient in the ED, beyond a certain number of hours, as determined by the WRHA, should be specifically considered by the Utilization Team for follow up. (para. 270)
- The WRHA move towards finalization of the regional overcapacity protocol. (para. 273)
- The WRHA review the initiative to move 19 geriatric patients out of SOGH to a long-term care facility and convert that space to 30 medicine beds, and consider whether the WRHA can move this initiative to a higher priority within the WRHA plan overall. (para. 292)
- The WRHA consider the feasibility of creating either an alternate space at SOGH for a unit similar to a Critical Decision Unit, where ED doctors can transfer patients, who are expected to remain in the ED for over 24 hours, to the HMO, or the WRHA consider the feasibility of a Hospitalist model at SOGH, where care of a patient is transferred to the care of a Hospitalist wherever the patient is located in the hospital. (para. 304)
- The WRHA consider the feasibility of adopting a pilot project at SOGH so that bed availability information is shared with the ED – and the ED is informed as to when the bed is cleaned and available. This information should be shared in paper format until it can be made available in electronic format. (para. 306)
- The WRHA consider creating a policy, to be provided to families involved in critical events, explaining what information will, and will not, be made available and an explanation of how communication and meetings between the parties will be dealt with through the review process. (para. 315)
- All patients requiring stays in the ED, of greater than 24 hours, should be admitted to hospital under the care of a dedicated physician and placed in an inpatient bed. Each site must develop a process to comply with this directive, in order to increase accountability and patient safety. (para. 336)
- The WRHA continue to work towards a fully implemented Regional policy that all patients requiring stays in the ED of greater than 24 hours, should be admitted to hospital under the care of a dedicated physician and placed in an inpatient bed. Each site should develop a process to comply with this directive, in order to increase accountability and patient safety. (para. 338)

- The University of Manitoba, Department of Emergency Medicine should collaborate with the WRHA Emergency and Occupational Therapy Programs to develop standards of care for Functional Assessments or have a screening tool of vulnerable patients in the ED. (para. 358)
- All WRHA hospitals should work with the Regional Occupational Therapy Program to ensure nursing based Functional Assessments are performed with patient safety as the foremost consideration. (para. 358)
- The WRHA consider designing and implementing a program on a Regional level, involving OT/PT, to ensure patients in the ED who remain longer than 24 hours, are mobilized regularly wherever possible. (para 360)
- That the RHAs review the feasibility of a seven-day workweek for the office of the Home Care Coordinator. (para. 367)
- The WRHA consider the feasibility of developing a model where: the role of Home Care Coordinators and Professional Nurses in the community is enhanced; that clients performance and functionality in the community is monitored; and if necessary, the type of care they are receiving in the community is enhanced, to avoid these clients from returning to the ED. (para. 371)
- The WRHA continue working to enhance the services of Home Care and Allied Health Workers to include staffing on weekends. (para. 372)
- The WRHA Emergency Program Guidelines for Safe Hand Off (May 2012) be implemented at all WRHA ED sites to ensure complete, safe and accurate exchange of information at handoff. (para. 386)
- The WRHA Emergency Program Guidelines for Safe Hand Offs be used as a template for developing a similar set of expectations and practice tools for handoff between sites. (para. 386)
- The WRHA consider creating a Safe Hand Off tool to be used in all EDs for patients remaining longer than 24 hours. The Safe Hand Off tool would be used at handover by all nurses and doctors involved in the patient's care. (para. 388)
- The WRHA continue to pursue education and culture change within the WRHA with the objective of including the patient and families in discussion of the patient status and treatment, including performing handovers at bedside. (para. 388)
- Documentation practice be specifically targeted for improvement through continuing education for current staff and also increased in the general orientation program for new ED nurses. (para. 389)

- The Emergency Program review and reinforce the need to report on all pertinent information including any specific adverse reactions or experiences and that these are properly documented and communicated by physicians and nurses giving or receiving report on a patient at hand off. (para 389)
- The WRHA Emergency Program Guideline for Safe Discharge be implemented beginning May 21, 2012, to provide better guidance for discharge planning. (para. 399)
- Senior Management and Emergency Leadership, at all sites, should be of the need to maintain a culture of patient safety in their EDs; regardless of the pressure to maintain patient flow. To this end, Physicians are encouraged to discharge patients only when it is safe and reasonable to do so. To that end, the Guidelines for Safe Discharge, that have now been implemented across all sites, should assist both Physicians and Nurses in ensuring the discharge plan developed for each patient is both appropriate and safe. Nursing and other staff, should be encouraged to make any patient related concerns known to the Physician, so that they can act as a check and balance for the Physician. (para. 399)
- The WRHA consider the feasibility of periodically determining the level of compliance the Guidelines for Safe Hand Off, Safe Discharge Guideline, the Safe Transportation Guideline and the Safe Patient Checklist, and that it seek ways to continually improve compliance. (para. 407)
- The WRHA Emergency Program Leadership work with site Emergency Departments to improve communication between staff and patients and their families, being sensitive to the stress experienced by patients during an emergency visit. (para. 408)
- Patients requiring stays in the ED, of greater than 24 hours, should be considered for prophylactic Heparin. Evidence based protocols should be developed to this end. (para.443)

XV. Witness List

1. Ms. Dana Brenan
2. Ms. Nayda Northage
3. Ms. Gail Thompson
4. Dr. Stanley Whyte
5. Ms. Claudine Knockaert
6. Dr. Mark Schneider
7. Ms. Courtney Maley
8. Dr. Neil Swirsky
9. Dr. Paul Dowhanik
10. Ms. Ali Collins
11. Ms. Deb Prideaux
12. Ms. Valerie Hachey
13. Ms. Martha Hyrnuik
14. Ms. Evelyn Hillary
15. Ms. Arvadell Egefz
16. Dr. Allan MicFlickier
17. Mr. Wayne Didkowski
18. Mr. Carl Anderson
19. Mr. Chris Rollwagen
20. Dr. Bojan Paunovic
21. Ms. Lori Lamont
22. Ms. Patricia Bergal
23. Dr. Ricardo Jorge Lobato de Faria
24. Dr. Alecs Chochinov
25. Ms. Karen Dunlop
26. Dr. Susan Phillips

XVI. Court Exhibit List

Exhibit 1	Letter from Dr. T. Balachandra directing the Inquest dated February 4, 2013
Exhibit 2	Documents received by the Inquest Office contained in 3 binders: Binder 1 Section 1(A, B) Section 2 (C) Binder 2 Section 2 (D - O) Binder 3 Section (P, Q)
Exhibit 3	Letter written by Dr. Renu Bhayana
Exhibit 4	Advance Care of Planning Goals and Care - Seven Oaks General Hospital
Exhibit 5	Seven Oaks General Hospital – E/R Bed Meeting
Exhibit 6	Curriculum Vitae of Dr. Susan Maxine Phillips
Exhibit 7	General Medicine Admission Order Set - six pages - entered by Mr. William Olson
Exhibit 8	Curriculum Vitae of Dr. Alex Chochinov
Exhibit 9	Definition of Nurse Practitioners
Exhibit 10	Definition of Physician Assistant

HEATHER DAWN BRENAN INQUEST

Documents Received By The Inquest Office

SECTION I:

DOCUMENTS PROVIDED BY THE OFFICE OF THE CHIEF MEDICAL EXAMINER (OCME):

A	**Office of the Chief Medical Examiner (OCME) File (#0123/12):**
A1	Title page (1 pg)
A2	Media Release from OCME dated February 12, 2013 (2 pgs)
A3	Letter to the Honourable Chief Judge Ken Champagne from Dr. A. Thambirajah Balachandra, Chief Medical Examiner, dated February 4, 2013 Re: calling the inquest (4 pgs)
A4	Letter to Dana Brenan from Mark O'Rourke, Director, OCME dated February 1, 2013 Re: calling the inquest (2 pgs)
A5	Geriatric Inquest Review Committee Review Form (1 pg)
A6	File Status - Medical Examiner Cases (1 pg)
A7	Report of Medical Examiner by Dr. S. Phillips dated May 18, 2012 (1 pg)
A8	Final Autopsy Report by Dr. S. Phillips dated May 16, 2012 (7 pgs)
A9	Preliminary Autopsy Report dated January 31, 2012 (2 pgs)
A10	Fatality Inquiries Act Autopsy Authority dated January 30, 2012 (1 pg)
A11	Preliminary Report of Death (2 pgs)
A12	Correspondence (38 pgs)
A13	Other (6 pgs)
A14	Medical Certificate of Death (2 pgs)
B	**Winnipeg Fire Paramedic Service File:**
B1	Patient Care Report (6 pgs)

SECTION II:

DOCUMENTS PROVIDED BY THE WINNIPEG REGONAL HEALTH AUTHORITY (WRHA) AND THE SEVEN OAKS GENERAL HOSPITAL (SOGH):

C	**Seven Oaks General Hospital Chart:**
C1	Typed note form OCME re: personal health information (1 pg)
C2	Emergency Treatment Record dated January 24, 2012 (1 pg)
C3	Triage Assessment Score (1 pg)
C4	Consultation Record (1 pg)
C5	Swallowing Assessment (1 pg)
C6	Transfer/Referral Form (1 pg)
C7	Integrated Patient Progress Notes January 24, 2012 -January 27, 2012 (7 pgs)
C8	Scheduled Medication (2 pgs)
C9	DPIN Dispensing History (2 pgs)
C10	FAX covering sheet and Lab Results dated January 24, 2012 (3 pgs)
C11	More Lab Results (6 pgs)
C12	EKG Report and Recording dated January 24, 2012 (2 pgs) .
C13	Diagnostic Imaging Reports (3 pgs)
C14	Notice of Referral, Occupational Therapy dated January 25, 2012 (1 pg)
C15	Occupational Therapy Initial Assessment dated January 26, 2012 (2 pgs)
C16	Social Work Assessment Form (1 pg)
C17	Triage Assessment Score (1 pg)
C18	Emergency Treatment Record (1 pg)
C19	Inpatient Demographics Sheet (1 pg)
C20	Death Summary dated January 28, 2012 (3 pgs)
C21	Integrated Progress Notes (7 pgs)

C22	ICU Standard Admission Orders (1 pg)
C23	Physician's Orders (6 pgs)
C24	Continuous IV Infusion Medications (3 pgs)
C25	Non-Scheduled Medications ICU (3 pgs)
C26	EKG Reports and Recordings dated January 28, 2012 (6 pgs)
C27	CT Scan of Brain (1 pg)
C28	Chest X-ray Report (1 pg)
C29	Lab Reports (8 pgs)
C30	Notification of Death (2pgs)
C31	Old Medical Records (8 pgs)

D	**Additional SOGH Medical Records:**
D1	Chemistry Lab Test Results (see C10.1)
D2	CBC Lab Test Results (see C10.2)
D3.1-.2	Notification of Death (see C30.1) (2 pages)
D4	SOGH Health Information Services -Letter to C. Tolton dated April 11, 2014
D5	WRHA Advance Care Plan completed dated January 24, 2012
D6	SOGH Patient Profile List (undated)
D7.1-.3	SOGH Admission Form (3 pages)
D8	SOGH Clinical Circumstances Sheet re January 24, 2012
D9	SOGH Medication Reconciliation and Order Form dated January 24, 2012
D10	SOGH Clinical Circumstances Sheet dated January 24, 2012
D11	SOGH Clinical Circumstances Sheet re January 28, 2012
D12	SOGH Inpatient Treatment Summary dated January 28, 2012
D13	SOGH Authorization to Review and Record of Disclosure to the Office of the Chief Medical Examiner of Manitoba dated January 30, 2012
D14	SOGH Signature/lnitial Record

D15	SOGH Specialist Consultation Form
D16.1-.2	SOGH ICU Patient Assessment Record dated January 28, 2012 (2 pages)
D17	SOGH Clinical Circumstances Sheet dated January 28, 2012
D18	Handwritten note of N. Cristall FPCM dated January 28, 2012
D19.1-.4	SOGH Integrated Progress Notes not included in C20 and following dated January 30, 2012 (4 pages)
D20	SOGH Code Blue Resuscitation Record dated January 28, 2012
D21	SOGH ICU Blood Gas Summary dated January 28, 2012
D22	SOGH ICU Cardiovascular Flow Sheet dated January 28, 2012
D23	SOGH ICU Catheter Data Record dated January 28, 2012
D24	SOGH ICU Ventilator Flow Sheet dated January 28, 2012
D25.1-.3	SOGH 24 Hour Fluid Balance Record dated January 28, 2012 (3 pages)
D26	SOGH Lab Report dated January 28, 2012
D27.1-.3	SOGH Patient Sample Reports dated January 28, 2012 (3 pages)
D28.1-.5	SOGH ECG Rhythm Strip Mounting Record dated January 28, 2012 (5 pages)
D29	SOGH Emergency Nursing Assessment dated January 24, 2012
D30	SOGH Clinical Circumstances Sheet dated January 24, 2012
D31.1-.3	SOGH Physician's Orders dated January 24-27, 2012 (3 pages)
D32.1-.2	SOGH Specialist Consultation Form dated January 26, 2012 (2 pages)
D33.1-.2	SOGH Physiotherapy Assessment Form dated January 26, 2012 (2 pages)
D34.1-.2	SOGH Level of Function (At Time of Transfer) dated January 27, 2012 (2 pages)
D35.1-.2	SOGH Notification of Referral - Physiotherapy dated January 25/11 (sic) (2 pages)
D36.1-.5	OR - Day Surgery Report from Dr. Micflikier at Victoria General Hospital dated January 27, 2012 (1 page with 4 pages attached)
D37	Prescription Summary sheet (undated)

D38.1-.3	Lab Results dated January 24, 2012 (3 pages)
D39	Victoria General Hospital Endoscopy Procedure Record dated January 27, 2012
D40.1-.2	SOGH Ventilator Flow Sheet dated January 26, 2012 (2 pages)
D41.1-.4	SOGH 24 Hour Fluid Balance Record dated January 24, 2011 (sic) (4 pages)
D42	SOGH Ventilator Flow Sheet dated January 25, 2012
D43.1-.5	Lab Results on blood work dated January 25-27, 2012 (5 pages)

PAST HISTORY

D44	SOGH Requisition for Diagnostic Service dated August 28, 2006
D45	SOGH Diagnostic Imaging Program sheet dated June 11, 2006
D46	SOGH Registration form dated October 21, 2005
D47	SOGH Rehabilitation Services Outpatient Discharge Summary dated October 21, 2005
D48	SOGH Patient Profile List (undated)
D49.1-.2	SOGH Peripheral Joint Assessment Form dated August 3, 2005 (2 pages)
D50	SOGH Integrated Progress Notes dated August 21, 2005
D51.1-.2	SOGH Rehabilitation Services Physiotherapy Total Knee Replacement Program sheet dated September 19, 2005 (2 pages)
D52	Concordia Hospital Requisition for Physiotherapy form dated July 14, 2005
D53	SOGH Requisition for Diagnostic Services dated June 16, 2005
D54	SOGH Diagnostic Imaging Program report dated September 16, 2005
D55	SOGH Registration form dated February 8, 2005
D56	SOGH Rehabilitation Services Outpatient Discharge Summary dated February 8, 2005
D57	SOGH Patient Profile List dated January 10, 2005

D58.1-.2	SOGH Peripheral Joint, Assessment form dated January 10, 2005 (2 pages)
D59	SOGH Integrated Progress Notes dated February 8, 2005
D60	SOGH Rehabilitation Services Physiotherapy Total Knee Replacement Program form dated February 7, 2005
D61	Concordia Hospital Requisition for Physiotherapy - Outpatient form dated January 10, 2005
D62	SOGH Requisition for Diagnostic Services dated October 16, 2003
D63	SOGH Diagnostic Imaging Program report dated April 5, 2004
D64	SOGH Requisition for Diagnostic Services form dated January 20, 2003
D65	SOGH Diagnostic Imaging Program form dated May 30, 2003
D66	SOGH Requisition for Diagnostic Services form dated July 15, 1999
D67	SOGH Diagnostic Imaging Services X-Ray Consultation report dated July 15, 1999
D68	SOGH Requisition for Diagnostic Services form dated May 14, 1999
D69	SOGH Diagnostic Imaging Services report dated June 7, 1999
D70	SOGH Requisition for Diagnostic Services form dated February 24, 1999
D71	SOGH Diagnostic Imaging Services report dated March 23, 1999
D72	SOGH Requisition for Diagnostic Services (undated)
D73	SOGH Diagnostic Imaging Services Report dated October 14, 1998
D74	SOGH Registration form dated April 27, 1998
D75	SOGH Emergency Treatment Record dated April 28, 1998
D76	SOGH Emergency Triage Record form dated April 27, 1998
D77.1-.2	SOGH Hematology Backing Sheets dated April & May, 1998 (2 pages)
D78	SOGH Microbiology Report dated April 29, 1998
D79	SOGH Requisition for Diagnostic Services dated October 29, 1997
D80	SOGH X-Ray Consultation Report dated October 29, 1997
D81	SBGH Biochemistry Report dated October 30, 1997

D82	SOGH Registration Admission form dated October 25, 1997
D83	SOGH Emergency Treatment Record dated October 26, 1997
D84	SOGH Emergency Triage Record dated October 25, 1997
D85	SOGH Integrated Process Notes dated October 26, 1997
D86.1-.2	SOGH Reports Backing Sheet dated October 26, 1997 (2 pages)
D87	SOGH Tissue & Cytology Report dated October 30, 1997
D88	SOGH X-Ray Consultation Report dated October 26, 1997
D89	SOGH Emergency Registration form dated August 25, 1991
D90	SOGH Emergency Treatment Record dated August 25, 1991
D91	SOGH Emergency Triage Record dated August 25, 1991
D92.1-.2	WRHA CI Disclosure Record form dated February 10, 2012 (2 pages)
D93	SOGH Emergency Request for Admission form dated January 28, 2012

E	**Administrative Review:**
E1.1-.11	Administrative Review dated May 10, 2012 (11 pages)

F	**Communications with Brenan Family:**
F1.1-.2	Email from WFP to WRHA dated February 23, 2012 with attached communication from Dana Brenan to WFP dated January 28, 2012 (2 pages)
F2	Email exchange between Real Cloutier and Leslie Drewniak dated February 25-26, 2012
F3	Email exchange between Real Cloutier and Fay and Wayne Ash dated February 25-26, 2012
F4.1-.2	Email exchange between Real Cloutier and Cindy Kahler-Krochak dated February 26, 2012 (2 pages)
F5.1-.2	Letter dated February 28, 2012 from Real Cloutier to Dana Brenan (2 pages)
F6	WFP article posted March 7, 2012 "Tories, family of senior want case examined"
F7	Email from Real Cloutier to D. Brenan dated March 23, 2012

F8	Email from Real Cloutier to Alecs Cochinov dated March 28, 2012
F9	Email from Real Cloutier to D.L. Brenan dated April 10, 2012
F10.1-.2	Email exchange between Real Cloutier and D. L. Brenan dated April 10, 2012 (2 pages)
F11.1-.3	Email exchange between Anita Kruk, WRHA and D. L. Brenan dated April 16 -19, 2013 (3 pages)
F12	Email exchange between Real Cloutier/L. Dahl at WRHA and D.L. Brenan dated May 24, 2012
F13.1-.3	Email exchange between L. Dahl, Real Cloutier and D.L. Brenan dated May 24, 2012 (3 pages)
F14.1-.3	Email exchange between L. Dahl, D.L. Brenan, Real Cloutier and Karen Dunlop dated May 24 -25, 2012 (3 pages)
F15.1-.2	Email exchange between Karen Dunlop and D.L. Brenan dated May 2528, 2012 (2 pages)
F16.1-.2	Typed Review Notes of meeting with Brenan family dated June 14, 2012 (2 pages)
F17	Email exchange between Real Cloutier and D.L. Brenan dated July 13, 2012
F18.1-.2	Email exchange between Real Cloutier and D.L. Brenan dated July 1323, 2012 (2 pages)
F19.1-.2	Email exchange between T. Kolody, D. L. Brenan and Real Cloutier dated July 23, 2012 (2 pages)
F20.1-.3	Email exchange between T. Kolody, D.L. Brenan and Real Cloutier dated July 23-24, 2012 (3 pages)
F21.1-.15	Letter of August 7, 2012 from Real Cloutier, WRHA to Dana Brenan with enclosures attached (see A12.25) (15 pages)

G	**SOGH Data Re: Patients:**
G1.1-.9	SOGH Patient Status from January' 24, 2012 at 12:24 a.m. to January 27, 2012 at 11:39 a.m. (9 pages)
G2	SOGH Patient Status as of January 27, 2012 at 11:36 a.m.
G3.1-.2	SOGH ED Total “To Be Admitted" Hours (TBADM) up to January 29, .2015 (2 pages)

H	**Institutional Information:**
H1.1-.15	Overview of the WRHA (undated) (15 pages)
H2.1-.8	SOGH Emergency Department Patient Guide (undated) (8 pages)
H3	SOGH Emergency Department Pod 3 Floor Plan as at 2012
H4.1-.2	SOGH Safe Hand Off Tool (Shot) (2 pages)
H5.1-.2	SOGH Instructions for Discharge (2 pages)
H6	Sign posted in SOGH ED in mid-2012

I	**ED Discharge Information:**
I1	Memo from Arlene Wilgosh to Lori Lamont re: Emergency Departments Discharge dated March 28, 2012
I2.1-.4	WRHA Emergency Program Guideline re: Safe Patient Discharge dated May 28, 2012 (4 pages)
I3	Emergency Department Patient Discharge Checklist, effective May 1, 2014
I4-1-.8	WRHA Safe Transportation Guideline effective May 1, 2014 (8 pages)
I5.1-.8	WRHA Emergency Program Guideline re: Safe Patient Discharge approved May 28, 2012 (draft) (8 pages)
I6.1-.11	Memorandum to WRHA Emergency Program dated January 16, 2015 attaching Safe Transportation Guideline approved December 1, 2014 (11 pages)
I7	Discharge Checklist in use at Clinical Doc Sites (undated)
I8.1-.3	Memorandum re: Aggregate Analysis of ED Critical Incidents (undated) (3 pages)
I9.1-.2	Memorandum re: Additional Scan of the CIRRA Database Related to CIs in the WHR ER Departments dated April 18, 2012 (2 pages)
I10	Email between Blair Stevenson, Program Director Specialty Care SOGH, to Karen Dunlop re: Safe Patient Discharge and Risk Reduction Strategies Implemented dated October 11, 2012

J	**Patient Flow and Acute Care:**
J1.1-.2	Email from Lori Lamont to Wendy Peppel with SOGH Stats for January 24-27, 2012 dated February 27, 2012 (2 pages)
J2.1-.5	Emails re: WRHA Weekly Flow Report and Community Initiatives Aimed at Improving Flow of ALC Patients September 5-17, 2014 (5 pages)
J3	Graph re: SOGH-Total ED Visits by Month April 1, 2012 - December 31, 2014
J4.1-.11	UMS Successes and Challenges in the Winnipeg Regional Health Authority: Our Amazing Race - dated October 2013 (11 pages)
J5.1-.2	Preparing For Manitoba's Boomers - Manitoba Centre for Health Policy dated October 2012 (2 pages)
J6.1-.13	Excerpt from Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036 dated October, 2012 (13 pages)
J7.1-.2	Accreditation Canada Required Organizational Practices ("ROP") for onsite surveys re: client flow starting January, 2015 (2 pages)
JS.1-.6	WRHA - High Risk Complex Clients and Patients who are Frequent Users of Health Services - Listing of Health and Social Service and/or Housing Initiatives dated January, 2014 (6 pages)
J9.1-.24	ED Flow Issues - Presentation to WRHA Board by Dr. Alecs Chochinov dated November 9, 2012 (24 pages)
J10.1-.72	Research and Evaluation Unit - Getting to the Source of the Patient Flow Problem: An Analysis of Flow-Related Initiatives in the Winnipeg Health Region dated June 18, 2013 (72 pages)
J11.1-.S	Excerpt from Who Is In Our Hospitals ... And Why? Manitoba Centre for Health Policy (undated) (8 pages)
J12.1-.3	Accreditation Canada Required Organizational Policy ("ROP") (formal release January, 2014 - any hospital. or RHA desiring to be accredited is required to comply) dated October 3, 2013 (3 pages)
J13.1-.2	WRHA Summary of Utilization Initiatives 1998 -2013 (undated) (2 pages)
J14.1-.5	Province Invests $5.7 Million to Strengthen Emergency Care - Province of Manitoba News Release dated March 26, 2009 (5 pages)

J15.1-.17 WRHA Health System Flow Status Report dated June, 2011 (17 pages)

J16.1-.2 Community and Long Term Care (ALC Strategy) dated December 8, 2010 (2 pages)

J17.1-.4 WRHA Survey of Bed Ratios for Emergency Care Task Force - December 22, 2004 (4 pages)

J18.1-.4 Regional Graphs - Hospital Hold Clients - 2006/2007 - 2012/2013 (4 pages)

J19.1-.4 Memorandum from COO, Long Term Care to Manitoba Health re: WRHA Weekly Panel and Placement Stats dated January 14, 2015 (4 pages)

J20.1-.4 Memorandum from COO, Long Term Care to Manitoba Health re WRHA Weekly Panel and Placement Stats dated January 21,2015 (4 pages)

J21.1-.6 WRHA: PCH and SH Housing Capacity and Changes by Years 2000 to March 31, 2014 (6 pages)

J22.1-.2 Seven Oaks General Hospital ED Total "To Be Admitted" Hours (TBADM) 2009 - 2014-15 YTD (2 pages)

K **Witness Information:**

K1.1-.7 WRHA Emergency Program Guidelines re: Roles and Responsibilities of the Clinical Resource Nurse in the WRHA Emergency Department Approval Date: January, 2012 (7 pages)

K2.1-.2 Memorandum of Carl Anderson, RN dated August 7, 2013 (2 pages)

K3.1-.4 Position Description - Medical Director, WRHA Emergency Program May 1, 2010 - April 30, 2015 (4 pages)

K4.1-8 Curriculum Vitae of Alecs Hart Chochinov (8 pages)

K5.1-.6 WRHA Position Description - Vice President and Chief Nursing Officer dated June 4, 2009 (6 pages)

K6.1-.8 Curriculum Vitae of Lori Lamont (8 pages)

K7.1-.2 Typed statement of Wayne Didkowski (2 pages)

L **Media Reports:**

L1.1-.2 Canadian Press article published January 27, 2014 (2 pages)

L2.1-.2 The Telegram article published February 19, 2014 (2 pages)

M **Statement Of Claim:**

M1.1-.20 Statement of Claim dated September, 2013 (20 pages)

N **Inquest Into the death Of Brian Lloyd Sinclair:**

N1.1-.41 Excerpts from the Brian Sinclair Inquest Report - Release Date: December 12, 2014 (41 pages)

N2 Selected Recommendations From the Brian Sinclair Inquest Report (undated)

O **Victoria General Hospital Records:**

O1.1-.15 VGH Health Records relating to the admission of H. Brenan on January 27, 2012 (15 pages)

XVII. Legislative Authority:

Sections 19, 25 and 26 of *The Fatality Inquiries Act* are the authority for a Provincial Court Judge to hold an Inquest:

CME review of investigation report

19(1) Subject to subsection (3), upon receipt of an investigation report, the chief medical examiner shall review the report and determine whether an inquest ought to be held.

CME to direct holding of an inquest

19(2) Where the chief medical examiner determines under subsection (1) that an inquest ought to be held, the chief medical examiner shall direct a provincial judge to hold an inquest.

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.

Ministerial direction for inquest

25 The Minister may direct a provincial judge to conduct an inquest with respect to a death to which the *Act* applies.

Provincial judge to hold inquest

26(1) Where a direction is given by the chief medical examiner under section 19 or by the minister under section 25, a provincial judge shall conduct an inquest.

Pursuant To Section 33(1),

It is the requirement of the Provincial Judge to complete a report after the hearing of the witnesses as follows:

Duties of provincial judge at inquest

33(1) After completion of an inquest, the presiding provincial judge shall

(a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of death, the name of the deceased person, if known, and the material circumstances of the death;

(b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and

(c) send a copy of the report to the medical examiner who examined the body of the deceased person;

and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.