Release Date: June 13, 2006

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATAL INQUIRIES ACT***

AND IN THE MATTER OF: **SHARON JOYCE HORN (Deceased)**

APPEARANCES:

MS. S. HEWITT-MICHTA, Counsel to the Inquest

MR. D. SWAYZE, Counsel for the Brandon Regional Health Authority

MR. R. PATTERSON, Counsel for the City of Brandon and Brandon Police Services

MR. B. MAYES, Counsel for Myrtle Wooldridge, sister of Sharon Joyce Horn

MR. M. THOMSON, Counsel for The Manitoba Schizophrenic Society

M A N I T O B A

The Fatal Inquiries Act

Report by Provincial Judge on Inquest

Respecting the death of: SHARON JOYCE HORN

At approximately noon on the 3rd of January, 2004, the frozen body of Sharon Joyce Horn, aged 57 years, was discovered by a person snowshoeing on a field at the northern edge of the City of Brandon. The Brandon City Police Services investigated and found no signs of foul play. An autopsy was performed and the cause of death was determined to be hypothermia.

Ms. Horn had been diagnosed with schizophrenia and had been a "client" of the mental health system virtually all of her adult life. From her early 20's she had either been a resident in a mental health institution or supervised in a residential care home until approximately two months prior to her death. At that time, Ms. Horn commenced living independently in her own apartment with support provided by Community Mental Health, a branch of the Brandon Regional Health Authority. As a result of her death, concerns have arisen as to the decision of Ms. Horn to live independently and in particular:

a) whether she was capable of living independently;
b) whether she was properly prepared to do so;
c) whether appropriate supports were in place or being utilized to assist her.

Shortly after her death, Ms. Horn's sister, Myrtle Wooldridge, discovered a note in Ms. Horn's personal possessions which could be interpreted as a suicide note. In the past, Ms. Horn had talked of suicide but there was no history of suicide attempts.

The Chief Medical Examiner for the Province of Manitoba directed that an inquiry pursuant to Section 19(2) of the Fatal Inquiries Act be held to determine the following:

a) the circumstances under which the death of Sharon Joyce Horn occurred;
b) what, if anything, can be done to prevent similar deaths from occurring in the future.

After appropriate notice, a hearing to determine standing was held and the following were granted standing to participate in the inquest proceedings:

a) the Brandon Regional Health Authority
b) the City of Brandon and Brandon Police Services
c) Myrtle Wooldridge, sister of the deceased
d) The Manitoba Schizophrenic Society

Evidence was heard for a total of 11 days and final submissions were heard on the 22nd of December, 2005.

At this time I wish to thank all counsel for their important contributions to these proceedings. In particular, I want to thank Ms. Hewitt-Michta, inquiry counsel, for her able organization of the evidence and on whose hard work I have relied upon for much of this report.

Attached hereto and forming part of my report is a schedule of all exhibits required to be filed by me. I am directing the Brandon Court Office to release all exhibits back to the appropriate counsel as requested.

DATED at the City of Brandon, in the Province of Manitoba, this 8th day of June, 2006.

John H. Combs, Provincial Court Judge

Copies to: Chief Medical Examiner (2)
Director, Public Prosecutions
Deputy Attorney General
Chief Judge, Provincial Court of Manitoba

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I Background

[1] Sharon Joyce Horn was born on September 12, 1946, and was the second youngest of five children. The inquest heard evidence from Myrtle Wooldridge, a sister of Ms. Horn, who was ten years older. She described Sharon Horn as someone who, in her youth, became increasingly difficult to live with until she was eventually hospitalized at the Brandon Mental Health Centre in 1965 at age 19.

[2] After a stay at the Brandon Mental Health Centre, she apparently returned home, only to be re-admitted in 1970 after threatening suicide. In June of 1970 she was diagnosed by the staff at BMHC as suffering from schizophrenia with a borderline personality. Her I.Q. (Intelligence Quotient) was measured at that time and in one test was determined to be between 70 and 72 and in another test in the low 80's. These results confirmed a finding of borderline intelligence and someone who was unlikely able to care for herself. Ms. Horn was apparently discharged from BMHC shortly after her second admission and was placed with a family in Brandon in what is labeled a "residential care home". This placement involves a situation where Ms. Horn resided in the community with a family who provided for most of her basic needs. Although she moved to different homes at least twice, Ms. Horn remained in a residential care home environment until approximately two months prior to her death.

[3] On September 10th, 2003, a decision was made by Community Mental Heath to remove Sharon Horn from her then current residential care home. Evidence was heard

that Ms. Horn was moved as a result of concerns about the care providers stemming from an incident or incidents involving another resident of that same home. Ms. Horn was moved temporarily thereafter within Brandon to a facility known as the Crisis Stabilization Unit, which is a short term facility for mental health patients in crisis. Ms. Horn remained in this facility for 26 days, (considerably longer than the typical resident of this facility) because there was no other suitable living arrangement available for her. Eventually Ms. Horn could no longer remain at the Crisis Stabilization Unit and on October 6th, 2003, she moved in to the residence of the Brandon Young Women's Christian Association. The Community Mental Heath workers did not consider this a living arrangement appropriate for Ms. Horn on a long term basis and, on November 1st, 2003, she moved into her own apartment to live independently for the first time in her life. The apartment was located in a building called Armstrong Place which has nine independent living quarters. It is connected to another facility known as Welcome Inn which has a social-recreational area and some further housing units. These facilities were, at the time, operated by a non-profit group and funding was received by the Brandon Regional Health Authority and the Provincial Government. Virtually all of the users of the facility and the residents are "clients" of the mental health system.

[4] Sharon Horn remained in this living arrangement until her death.

[5] On the 2nd day of January, 2004, at approximately 3:30 p.m., the Brandon Police Service received a call from a concerned citizen reporting that about 35 minutes

earlier, while traveling on a busy street in the City of Brandon, she had seen a woman walking over the Eighteenth Street Bridge. She expressed concerns that the woman seemed disorientated and was inappropriately dressed for the cold weather conditions. A police unit was dispatched to the location where this individual was seen. A search of the area was conducted by the attending officer but he was unsuccessful in locating the person described by the caller. The body of Sharon Horn was found the next day not far from the location described by the caller. This factor along with the description provided by the caller leads to reasonable conclusion that the person seen on January 2nd, 2004, was, in fact, Sharon Horn.

II Schizophrenia

[6] Sharon Horn was diagnosed in 1970 as someone who was suffering from schizophrenia. In determining what may have caused the death of Sharon Horn and in assessing the appropriateness of decisions made by government or quasi-government agencies in their dealings with Ms. Horn, a basic understanding of the illness is required. This inquiry heard much evidence about the disease of schizophrenia and, in particular, received evidence from Dr. Manohary Vipulananthan (Dr. Mano) who was Ms. Horn's psychiatrist from 1994 till the date of her death. Dr. Mano outlined, in general terms, information about the illness of schizophrenia, its effects on Sharon Horn and how she treated her for her mental health issues.

[7] As Dr. Mano describes it, the current theory is that schizophrenia is a neurobiological illness caused by changes in the neurons of the brain. This results in an imbalance of neurochemicals which transfer perception and emotions from one cell to the other. It is a chronic illness which impacts on the person's thinking, feelings and perception. About one percent of the population suffers from schizophrenia and it is an illness which has no relationship to intelligence. People of high and low intelligence can be schizophrenic.

[8] Schizophrenia typically will start to manifest itself when a person is between 16 and 30, although generally earlier for men.

[9] The cause of schizophrenia is unknown and different theories have been espoused, including that the illness is viral or as a result of a birth defect. In many cases, a person may have a pre-disposition for the illness as a result of a family history of schizophrenia (i.e. a genetic pre-disposition). Events in a person's life may trigger the illness, such as drug and alcohol abuse or severe stress.

[10] Schizophrenia can be exhibited in many different ways and to different degrees. Some sufferers could experience one episode of short duration and completely recover in that there is no repetition of the symptoms. Others may have symptoms that never or rarely abate but only may fluctuate as to their intensity. Some may experience symptoms somewhere between these extremes.

[11] The symptoms of someone experiencing schizophrenia also vary greatly. A person suffering from this illness generally feels lonely and disconnected from their surroundings and other people. The reality of the world is often different from the perception of the patient. The person may experience delusions, hallucinations and be disorganized in his/her speech and/or behavior. This is particularly so during an acute stage of the illness when a sufferer can experience a psychotic episode and cannot delineate the difference between the real and the unreal.

[12] The most common symptom of schizophrenia, however, is social withdraw. The individual may experience fatigue or a lack of energy, a decrease in social interaction and difficulty enjoying life. This usually results in a decreased ability to perform at work or to learn new tasks or skills and can lead to depression or suicidal tendencies. One common sign of deterioration in a sufferer's health (particularly a person with lower intellectual functioning) is a reduction in attention to one's personal care and hygiene. It is also common that a person going through an acute stage of their illness will experience fear and anxiety.

[13] Schizophrenia is usually diagnosed by attempting to eliminate other causes of the behavior described and, once those other causes are eliminated, the person continues to exhibit these symptoms for a long period of time (at least six months). To be considered schizophrenia, the behavior exhibited should result in a marked social and/or occupational dysfunction.

[14] Schizophrenia is not curable but a person can recover from the illness by having the symptoms treated. The illness will invariably result in progressive deterioration of the individual but the process can be slowed by effective treatment.

[15] The actual treatment of schizophrenia involves different components including medical, psychosocial rehabilitation and psycho-education. The medical component involves the use of medication to treat or reduce the symptoms and to prevent relapse. The medication used is typically an anti-psychotic which is effective in treating most symptoms.

[16] The psychosocial rehabilitative component typically means providing supports to patients to allow them to remain active in, or to reintegrate them into the community. This aspect of treatment would include learning or relearning life skills or coping skills which would allow a patient to function effectively and optimally in the community. The psycho-educational component of treatment promotes educating the patient, the patient's family and any care providers or support people about the illness. This includes learning what the symptoms of the illness are, what may cause a relapse, and how the illness should be treated. In particular, family members should be aware of what behavior on their part might cause a relapse. This information can only be shared with family members after receiving the consent of the patient.

[17] A person suffering from schizophrenia generally experiences periods of relapse when symptoms return and the person starts to deteriorate. A most common sign of relapse is withdrawal of the patient from normal activities and social interaction and deterioration in personal care and hygiene. Many people suffering from schizophrenia attempt or commit suicide. We heard at evidence that between five to ten percent of schizophrenia sufferers commit suicide and 15 to 40 percent attempt suicide.

[18] In treating schizophrenia therefore, it is therefore crucial that all people interacting with that individual, whether they be health care professionals, care providers or family, be aware of the causes and symptoms of relapse for that particular patient. This awareness is best developed by establishing a trusting relationship with the patient so the patient will share his or her thoughts and feelings. This will enhance the ability of the health care professional, care givers or family members to assist the patient in doing what is necessary to avoid relapse or deal with relapse, when it occurs, with the least amount of damage.

III The Treatment of Mental Health Patients

[19] This inquest received evidence from many witnesses about the developments in the treatment of mental illnesses. The inquest specifically heard from Albert Hajes, the coordinator of Mental Health Services for the Brandon Regional Health Authority and from Chris Summerville, the Executive Director of the Manitoba Schizophrenic Society about the shift in the emphasis of the treatment of mental illnesses. The Manitoba

Schizophrenic Society is a self-help organization assisting sufferers of schizophrenia and their families in an attempt to enhance the lives of those individuals who have schizophrenia.

[20] People who have suffered from mental illnesses and, in particular, serious mental illnesses such as schizophrenia, have traditionally been ostracized from our society. They were often institutionalized and separated from the rest of the community, quite often for lengthy periods of time. The mentally ill were thought to be incompetent and incapable of looking after themselves. Friends and family members would distance themselves from the patient and they would become marginalized from society and stigmatized as being crazy.

[21] The primary treatment of individuals with a serious mental illness was the use of medication to control or reduce symptoms. There was little emphasis on developing skills to enhance the reintegration of the mental health patient back into the community. This narrow approach to assisting the mental health patient has been labeled the "treatment model".

[22] The treatment of these patients occurred primarily within an institutional setting. Debbie Wickstrom, currently the program manager for Adult Community Mental Health with the BRHA, described working at the Brandon Mental Health Centre in the mid 1970's. The hospital was divided into wards with 50 or 60 patients per ward. The

entire day was a series of routines. All patients would be awakened at the same time, line up for the bathroom and be handed their clothes for the day. They would then line up for their meals all at the same time and then line up for their medications. The patients had to adjust to the routines of the day and had no participation in deciding their daily activities. Ms. Wickstrom described this process to be like "herding" rather than care giving. The wards were always locked and the patients could not leave without a pass. All of the decisions concerning the care of the patient were made by the medical doctors, only some of which were psychiatrists. Individuals such as Ms. Wickstrom, a registered psychiatric nurse, were allowed little involvement with medical decisions and took direction from the doctors.

[23] Obviously, in this environment, there was little opportunity for the patient to develop new skills or reacquire skills lost as a result of their mental illness. Little emphasis was placed on preparing the patient for his or her eventual discharge from the institutional environment.

[24] In the late 1970's, the medical community increasingly realized that mental health patients could manage in the community and deinstitutionalization became accelerated. Whereas the Brandon Mental Health Centre in the 1950's reached a maximum patient population of 1,689 persons, by the 1970's this number had been reduced to around 800 and, when BMHC eventually closed in 1994, there were about 250 to 300 patients left in the institution. The final closure of BMHC occurred as a result of a

report of Don Orchard, former Minister of Health for the Province of Manitoba. His report apparently emphasized three main principles:

a) Clients should be treated in the community wherever possible and services should be provided to them where they live;
b) There should be attempts to reduce the medical intervention with clients and focus on the individual needs of the client to enhance their ability to function in the community;
c) People should be moved out of an institution and into the community.

[25] This report recommended the closure of the Brandon Mental Health Centre.

[26] The move to close mental institutions arose as a result of the changing approach to treating people with mental illnesses. It was recognized that most patients could function in the community. As a result, more resources were allocated and supports put in place to assist the mentally ill in developing and regaining skills which would facilitate their participation in society to their full capacity. Mr. Hajes described three main objectives of the treatment of mental health patients:

1) To develop skills and provide supports to the client so they could function at their optimum level in the community;
2) To assist the patient in assuming a normal role in the community;
3) To regain old skill or develop their capabilities so they could participate as a full citizen and with a high degree of involvement in the community.

[27] As Mr. Summerville pointed out in his evidence, these goals can best be accomplished through a holistic approach to treatment. Treatment should involve many perspectives including biochemical, psychosocial, spiritual, recovery and empowerment. The biochemical component acknowledges that many clients need medication to treat and control their symptoms. Medical staff and care givers should be trained to see signs of deterioration or an acute episode, consult with the psychiatrist and arrange for medication, if necessary. The psychosocial component acknowledges that clients should be helped to develop interpersonal skills that will allow them to interact with others in the community with an emphasis on stress management and conflict resolution. The health care professionals should develop a therapeutic relationship with the client that will allow them to assist in establishing rehabilitative and counselling goals and to help in the achievement of those goals. The spiritual and recovery component stresses that clients should be encouraged to develop hopes and dreams for their future. This might include more independence, greater involvement in community activities or even employment. The treatment providers should help the clients set goals that are realistic considering their health and help determine how these goals may be achieved. The empowerment component acknowledges that all treatment should be client centered and, as much as possible, client directed. Unless the client has been deemed to be incompetent under the *Mental Health Act*, the client has the right to make all decisions regarding the treatment they receive. The role of the medical staff is to assist the client in arriving at care decisions that will best enhance their recovery period.

[28] This approach to the treatment of mental health patients has been labeled the "recovery model", has been adopted by Mental Health Services in Brandon and is the basis for all care decisions made respecting the treatment of mental health patients. This is an important backdrop in assessing and analyzing decisions made concerning the care of Sharon Horn.

IV Sharon Horn and the Mental Health System

[29] Sharon Horn had been a client of the Mental Health System virtually all of her adult life. After her second admission to the Brandon Mental Health Centre in 1970, she was discharged into the community to live in a residential care placement. As referred to earlier in this report, she lived in a series of such placements until approximately two months prior to her death. In order to properly assess decisions made regarding Ms. Horn's care, her illness, how it affected her personality, and her relationship with her care providers were explored in this inquiry.

Sharon Horn's Personality

[30] In analyzing and assessing Ms. Horn's relationship with the mental health system, it is important to understand her personality and how her illness affected her. Sharon Horn was universally and consistently described by the caregivers within the mental health system as a kind, pleasant person with a positive outlook towards other people. She was someone who wanted to please people and was disturbed by conflict. In order to avoid confrontation, she would sometimes agree to things other people wanted

and would give caregivers information she felt they wanted to hear. For instance, she might say she was feeling wonderful even at times that there were evident signs of her illness having relapsed. She was someone who did not want to be a burden to other people. She was described as very proper and conscious of social graces.

[31] Sharon Horn's personality can be partially explained by her perception of herself as a bad person. She suggested that as a youth she was problematic in that she smoked, drank, and was angry with her parents. She felt responsible for her mother becoming ill and blamed herself ultimately for her mother's death. She felt that her illness was punishment for her bad behavior and, as a result, she strived to live a purer life.

[32] The one person who described a different Sharon Horn in these proceedings was her sister, Myrtle Wooldridge. Ms. Wooldridge felt Sharon was a mean person who was deliberately unpleasant to her family, particularly her mother. She believed Ms. Horn was pleasant to people only if they had something to give her. Sharon used to complain to her about people in her life, particularly her mental health worker. Ms. Wooldridge did concede, however, that most of her contact with her sister was when Sharon Horn was still at home (prior to 1970) and that she had virtually no contact with her prior to 1998. She confirmed that she probably saw Sharon Horn in person approximately seven times from 1998 until her death. It seems that much of Ms.

Wooldridge's description of Sharon Horn's personality was based on her recollection of her when Sharon was at home, undiagnosed, and obviously not receiving treatment.

Sharon Horn's Illness

[33] Sharon Horn was a mental health patient with an illness that could be managed in the community. After her release from the Brandon Mental Health Centre, there was no indication of any major psychotic episode. Ms. Horn could get around Brandon by taking the bus on her own or walking, and was able to attend activities in the community. Although she was never considered a candidate for employment, she was able to be active, could relate appropriately to other people and was well mannered.

[34] Relapses of her illness would be manifested by withdrawal from social contact or any other organized activities. She could become agitated and there might be deterioration in her physical appearance or her personal hygiene. She may not be sleeping well or there may be changes in her mood. Her psychiatrist, Dr. Mano, suggested that she could show signs of paranoia or experience some auditory hallucinations or delusional ideas. She also testified that these symptoms were never dramatic or acute with Ms. Horn and, once detected by the heath care professionals, would moderate or stop, typically with changes to her medication.

[35] In 1996, Dr. Mano did a full psychiatric assessment of Sharon Horn and, at its conclusion, was uncertain whether schizophrenia was the correct diagnosis for her. This

doubt was based primarily on the marked improvement Ms. Horn had experienced when she was placed on anti-depressant medication in the early 1990's. She became considerably more outgoing, much more social and seemed generally to be happier. Dr. Mano therefore believed that Ms. Horn may have suffered from major depression with psychotic features rather than schizophrenia. This doubt about her diagnosis seems to be of little importance in these proceedings as there was no evidence presented suggesting that the medications she was receiving were not appropriately dealing with her symptoms.

[36] Dr. Mano also believed that Ms. Horn was functioning at a higher intelligence level than indicated in the I.Q. tests performed on her when she was at the Brandon Mental Health Centre in 1970. At that time, two tests showed her I.Q. to be in the 70's to low 80's, which is of borderline intelligence. Someone with an I.Q. this low would typically be unable to live independently in the community. Dr. Mano expressed the opinion that the results referred to above may have been so low because Ms. Horn was sick at the time and her treatment was just commencing. Also, she suggested that I.Q. testing has improved considerably over the years and was less accurate back in 1970.

Medication

[37] One component of the treatment of Ms. Horn's illness consisted of drug therapy. She was receiving an anti-psychotic, which was initially administered by injection but came to be administered orally on a transitional basis in the years 2000 to

2001. Ms. Horn was also taking an anti-depressant and medication to help her sleep. In addition, she had various physical ailments which were also being treated with medication. All indications were that these medications were effectively controlling her symptoms and Ms. Horn did not complain of any dramatic side effects. The only concern raised about Ms. Horn's medication was by her sister, Myrtle Wooldridge, who questioned changes made to Sharon Horn's medication. This concern was based on the fact that Ms. Horn would contact her and express that she was not feeling well. This concern was never passed along to the health care providers by Ms. Wooldridge.

Residential Care

[38] From her discharge from the Brandon Mental Health Centre in 1970 until September of 2003, Sharon Horn lived in the community of Brandon in various homes which provided residential care. In order for a home to become eligible to provide this service, a licensing process has to be completed. The care provider within the home has to be deemed qualified after completing a first aid course, a criminal record check and an interview. The home itself needs to be physically adequate in that the space to be provided for the client would have to be suitable and in accordance with existing fire regulations. From 1970 to 2003, Sharon Horn lived in three separate residential care homes. We learned that Ms. Horn lived in her first residential care placement from her discharge from BMHC in 1970 until May 31st of 1996. Little evidence was presented about this placement except that it was described as a sterile environment with little stimulation for Ms. Horn. It was suggested that she was cared for adequately but there

was no attempt to increase her skill level in any manner as it related to her personal functioning or her ability to interact in the community.

[39] Ms. Horn then moved into the home of Pat Kallusky in May of 1996. Ms. Kallusky gave evidence in these proceedings. She is a registered nurse who had been providing residential care since 1992. She stated that when Sharon came to live with her, she was told by the Community Mental Health worker that she would be expected to provide meals for Ms. Horn, do her laundry, ensure that she took her medication and help her with her personal finances.

[40] Ms. Kallusky described Sharon Horn as someone who arrived at her home with few personal skills. She was afraid of taking a bath and had been used to sponge bathing. She was unable to keep her room clean. She ate primarily with her fingers and did not know how to effectively use a knife and fork. Ms. Kallusky stated that she encouraged her to take baths, taught her to clean her room and to use cutlery. Ms. Horn could apparently dress herself but required assistance in picking clothes that matched. She was able to choose appropriate clothing for existing weather conditions and always wore adequate clothing if the temperature was cold.

[41] Ms. Kallusky further stated that Ms. Horn was capable of taking the bus or walking on her own if she had an activity or an appointment. Otherwise, she would

spend most of her time in her bedroom and spent little time interacting with the Kallusky family.

[42] Sharon Horn would apparently take long walks but Ms. Kallusky tried to impress upon her not to walk too far from the house. In Ms. Kallusky's opinion, Ms. Horn would sometimes walk further away from the house than she should, but she was not aware of any time when she became lost while walking.

[43] Debbie Wickstrom gave evidence that she was Sharon Horn's mental health worker from December 3rd, 2001 until March or April of 2003. As such, she completed an annual assessment of Sharon Horn's residential care placement and completed such an assessment on January 31st, 2002. This assessment included a conclusion that Sharon was doing well in the Kallusky home and enjoyed living with Pat Kallusky. It was also determined that, in contrast to her previous residential care placement, Sharon Horn's level of functioning had improved. She was participating in programming arranged by Community Mental Health and her level of interaction with others had increased. Her personal hygiene was good and her nutritional and safety needs were being met by her care provider.

[44] At the same time, the assessment identified the need for a financial plan for Ms. Horn. She was receiving funds through income assistance but was not spending this money. Although she had many items that she needed, Ms. Horn was reluctant to spend

money and needed to be encouraged to make purchases. It was determined that Sharon needed more help in identifying her needs and shopping for the items she required. She needed assistance in keeping track of her money, making change when she made purchases and doing day to day banking. Ms. Kallusky, as a care provider, was expected to provide this assistance. At the same time, a list was prepared of items that Ms. Horn should purchase with Ms. Kallusky's assistance.

[45] It was about this time, in early 2002, that Ms. Kallusky expressed a reluctance to continue providing personal care, apparently for health reasons. Debbie Wickstrom gave evidence that Sharon Horn started to become apprehensive because of the uncertainty of her living situation and her health started to deteriorate. She became very stressed and started to withdrawal from programming. She remained this way until a new placement was found for her in May of 2002.

[46] Sharon Horn moved in May of 2002 to live with the Gagnon family, her last residential care placement. The primary care provider was Marie Gagnon, who is also a licensed practical nurse but has been unable to work at that profession for some time because of a back injury.

[47] Ms. Gagnon, like most others who gave evidence, described Sharon Horn as a good person, easy to get along with and eager to please. She provided all of her meals, gave out her medication and watched her ingest it. She accompanied Ms. Horn to all of

her doctors appointments. Although Sharon would remove money from her bank account, Ms. Gagnon would handle the money, make most of her purchases and give Sharon a small allowance.

[48] Ms. Gagnon described Ms. Horn's schedule of activities. She would make her way on a daily basis to the Welcome Inn (a gathering place for people within the Mental Health System) where she would play games, read and have coffee or tea. She would attend evening events including a weekly visit to a local United Church where she would participate in some meal preparation. At this time, she also had a proctor assigned to assist her with her integration in the community. The proctor's name was Jean Hoeppner, and she would take her on outings such as movies or walking in the mall.

[49] Ms. Gagnon commented that Sharon Horn enjoyed walking. She would go for long walks or walk to a restaurant which was close by. She would always say when she would be returning and was always on time. She would choose her own clothing for her outdoor walks and was always dressed appropriately for the weather. Ms. Gagnon gave the opinion that during the time that Ms. Horn was at her residence, she seemed happy and adjusted well to living in their home.

V Removal of Sharon Horn from Residential Care

[50] On September 10th, 2003, Sharon Horn was removed from the Gagnon residence. This decision was made by staff of Community Mental Health and came

about as a result of an incident involving a second resident of the Gagnon home named Joan. Although the circumstances surrounding this decision did not directly involve Ms. Horn, we heard evidence about the incident as it was instructive to hear how the incident was handled, considering the effect it would have on Sharon Horn.

[51] We were told that Marie Gagnon accompanied the other resident, Joan, to an appointment with an urologist. Apparently Joan was suffering from incontinence and, during the appointment, Ms. Gagnon pointed out to the doctor that a previous specialist had suggested that surgery was the only remedy for Joan's condition. Surgery was then recommended and Joan somewhat reluctantly agreed to the procedure. A consent form was then given to Ms. Gagnon to review with Joan outside of the doctor's office. Joan was reluctant to sign the consent form as it mentioned the possibility of a blood transfusion. Ms. Gagnon apparently suggested that a blood transfusion was unlikely and convinced her to sign the form.

[52] Joan left the doctor's office and went straight to her mental health worker. She told the mental health worker that she felt coerced by Ms. Gagnon to sign the consent even though she did not want surgery. She was particularly upset because of the possibility of a blood transfusion as she was a Jehovah's Witness.

[53] Ms. Gagnon, in her evidence, denied pressuring Joan into agreeing to the surgery but did believe it was best for her. She was also unaware that Joan was a

Jehovah's Witness and that accepting a blood transfusion would be contrary to her beliefs.

[54] The mental health worker who received the complaint from Joan went to her superiors. She met with Debbie Wickstrom, who by then had been promoted to be Program Manager for Adult Community Mental Health (supervisor of mental health workers), Marlene Fitzsimmons, who was another program manager in charge of residential services; and Jim Coates, in charge of residential care licensing. It was immediately decided that Joan would not return to the Gagnon home. The group felt that Joan had been treated with such disrespect and such little regard for her feelings that returning her to the Gagnon home was not an option.

[55] The decision was made to also remove Sharon Horn from the Gagnon home. As explained by Debbie Wickstrom in her evidence, it was agreed that if one mental health patient was being removed from the home, all individuals connected with the Mental Health System should be removed. She opined that Sharon Horn did not like conflict and that all of the workers were concerned that there might be considerable "negativity" in the Gagnon home resulting from their decision. Sharon Horn was removed immediately and the Gagnon care license was revoked. Ms. Gagnon was given no opportunity to explain her actions or give her version of events.

[56] The decision to remove Sharon Horn from the Gagnon home was made in spite of the fact that she seemed content in that placement and had not experienced any personal conflict with anyone in the home. She was not consulted in any way about the decision which is contrary to the "client centered philosophy of mental health treatment" espoused by Brandon Community Mental Health.

[57] Also excluded from the decision was Sharon Horn's mental health worker, Gerald Isaac, who was given instructions to pick Sharon up and take her to the Crisis Stabilization Unit and to tell her that she was not returning home. He was given no explanation as to the reason for such drastic action so obviously was not able to provide an explanation to Ms. Horn. Mr. Isaac, when he gave his evidence, seemed to believe that Ms. Horn accepted the move in her stride, but, considering what we heard about Ms. Horn's reaction to prior moves in her life and the stress this has caused her, this move and the way it occurred was bound to be traumatic and stressful for her.

[58] It is also clear that the decision to move Ms. Horn was made without any consideration as to where she might ultimately live. We heard evidence from Ms. Wickstrom that there were no residential care placements available but she was confident that an appropriate home could be found for Ms. Horn with adequate supports and programming. Ms. Wickstrom acknowledged that it would have been preferable for Ms. Horn to be involved with the decision to move her and that the mental health worker, Mr. Isaac, also should have been consulted. Ms. Wickstrom and Ms. Fitzsimmons both

maintain that, even in retrospect, removing Sharon Horn from the Gagnon residence was the appropriate decision.

VI The Transition from Residential Care to Independent Living

[59] It was acknowledged by those who gave evidence as representatives of Community Mental Health that when Sharon Horn was removed from residential care, no planning had been made for her future home. Although not admitted, it was obvious that no consideration had been given as to whether there was any suitable placement for Sharon Horn in the community.

[60] Sharon Horn had lived most of her adult life in residential care homes with people providing most of her needs. Community Mental Health in Brandon had been in the process of phasing out residential care homes for some time and no spots were available in September of 2003. Albert Hajes, coordinator of the Mental Health Program for the Brandon Regional Health Authority pointed out that the residential care model "is not favored" and is seen to be contrary to the recovery model of treatment. These placements are viewed as a continuation of the "custodial care era" and as undermining the client's ability to develop skills and move towards greater independence. It was evident from Mr. Hajes that maintaining or expanding residential care placements should not be a priority of the Mental Health System.

[61] When Sharon Horn was removed from the Gagnon residence, she was taken to the Crisis Stabilization Unit which, as the name implies, is a facility where people experiencing a crisis related to mental illness can stay on a short term basis. The unit has eight beds and is a converted heritage house. It has kitchen facilities where clients can get their own breakfast but other meals are provided. The average stay at the unit is four days and the focus is on stabilizing clients to allow them to return to their former homes or another appropriate placement.

[62] This was obviously just a place for Sharon Horn to stay until appropriate accommodation was found for her as she did not fit the criteria of an individual in a mental health crisis.

[63] Gerald Isaac had become Sharon Horn's mental health worker in April of 2003. He had not previously been a mental health worker and was to learn, as he stated in his evidence, that it was his job to find another place for her to live. As she had not been declared mentally incompetent under the *Mental Health Act* of Manitoba, she was free to live where she wanted. Community Mental Health had no right or obligation in law to determine where or how she lived. It was evident in her case, however, that Ms. Horn was someone who had become dependent on the Mental Health System to provide for her care and had never been given any indication that this would change. It was also clear that Ms. Horn had never mentioned to anyone who gave evidence in these proceedings that she wished to live more independently or had the skills to do so.

[64] Mr. Isaac was not aware on September 10th, 2003, that there were no residential care placements available and assumed she would be moved into another similar placement. He was also quite clear in his evidence that Ms. Horn would have preferred to be placed in another residential care home, an arrangement to which she was obviously familiar and comfortable.

[65] On September 12th, 2003, Mr. Isaac met with Ms. Horn again and, for the first time, she mentioned that she has been thinking about living on her own. She seemed aware that she would have to develop further skills before she would be ready to live independently but expressed an interest in exploring that option. Mr. Isaac, for his part, believed that Ms. Horn has been "stifled" in residential care and was capable of a more independent lifestyle.

[66] Mr. Isaac and Ms. Horn met again on September 15th, 2003. Mr. Isaac, in his notes, mentioned that Ms. Horn seemed bright and happy but disclosed that two days earlier, on September 13th, she had been very upset, was not sleeping well and had started smoking again. Mr. Isaac also noted that Ms. Horn was passively suicidal. When questioned about this insertion in his notes, Mr. Isaac explained that Ms. Horn did not directly threaten to cause herself harm but made a comment something like, "I don't know how I can continue". Mr. Isaac was of the opinion that this statement could have many meanings and did not consider it to be a threat to commit suicide. He was not

overly alarmed by this conversation as, by that time, Ms. Horn was feeling better and had apparently utilized the staff at the Crisis Stabilization Unit to help calm her anxieties.

[67] Mr. Isaac's notes of September 15th, 2003, make reference to some other important events. On that date, Mr. Isaac learned that there would definitely be no residential care placement available for Ms. Horn. Also, at a meeting with Marlene Fitzsimmons; Brent White, who is the manager of Residential and Community Services; and Jim Coates, it was decided that a more independent living arrangement should be considered for Ms. Horn. One option considered to be appropriate would be a proctor supported placement of shared accommodation with two or three other clients. Proctors would take shifts living in the residence and would provide the necessary support to allow this somewhat independent living situation. In order for this proposal to reach fruition, other suitable mental health clients would have to be identified, suitable and affordable accommodation would have to be identified and proctor support put in place. Sharon Horn was not invited to nor was she part of these deliberations.

[68] As part of the process of finding a suitable living arrangement for Ms. Horn, an assessment had to be completed as to the skills she had to live independently and steps taken to develop those skills to an acceptable level. To that end, Mr. Isaac asked the staff at the Crisis Stabilization Unit to "keep an eye on Ms. Horn to monitor her progress in performing daily chores such as laundry and helping out in the kitchen". He also asked them to put the onus on her to ask for her medication to determine if she could appreciate,

without any prompting, when her medication was due. It is important to note, however, that the staff of the Crisis Stabilization Unit was not equipped or trained to perform any kind of formal assessment to determine whether Sharon Horn had the necessary skills to live independently. The staff did not have the time to teach these skills and were not asked to do so.

[69] Mr. Isaac was also learning that there were few residential options available for someone such as Ms. Horn. He met with her again on September 16th, 2003, and advised her that there were no residential care placements for her. He also told her that, to date, they had been unable to arrange a shared living arrangement with proctor support and, if they didn't do so within a week, she would have to move to the YWCA residence and also apply for accommodation through Manitoba Housing. At this time, Ms. Horn again confirmed that she believed she could learn to live independently.

[70] Knowing that any future home for Ms. Horn would likely entail greater independence, steps were taken by Mr. Isaac to assist her with this transition. Firstly, as indicated, some monitoring of her progress was occurring at the Crisis Stabilization Unit. They noted that she was able to operate the laundry machines and generally had been able to tell the staff when she needed to take her medication.

[71] Secondly, Gerald Isaac arranged to increase the hours that Sharon spent with a proctor from approximately four hours per week to eight hours per week. The proctor

was seen as someone who would have a crucial role in assisting someone like Sharon Horn in learning to live independently. Proctors within the Mental Health System provide two types of support to the client and these are described as ongoing support and rehabilitative support. Ongoing support consists of providing social and other types of assistance to the client to enhance his or her functioning in the community. This would include assisting the client in becoming involved in community events, programs and social activities. The goal is to help the client connect with the community. Rehabilitative support includes assisting the client in improving his or her skill base functions in the community. The services provided by the proctor are determined by the client's needs, the service plan for the client, risk factors involving the client and the client's level of functioning. Ms. Horn had had a proctor for approximately the last year. Jean Hoeppner had worked with Sharon Horn in this capacity from early 2002. She would take Ms. Horn out to various activities including movies, dinners out, walks in the mall, et cetera. She recalls being given information about Ms. Horn's illness but doesn't recall ever being told specific signs to look for by way of warning signs which might show that Ms. Horn was in distress. She also confirmed that she was never asked to assist Ms. Horn in learning to live independently and never did so. This evidence is obviously in contrast to that of Mr. Isaac, who indicated that the proctor hours were included for that purpose.

[72] A third step taken by Mr. Isaac to assist Ms. Horn was to arrange for her to have access to programming at a facility known as McTavish Manor for a few hours each

week. McTavish Manor is a ten-bed transitional residential program where clients re-learn old skills or learn new skills which would assist them in living independently in the community. The facility has a kitchen and dining room where clients learn to cook and clean. The clients typically enter the facility having set a rehabilitation goal, are assessed for their skill level for reaching that goal, and are then given training and skill teaching to help them develop the skills to achieve their goal. McTavish Manor is considered a relatively long term placement with the average stay being at least one month. It is staffed by psychiatric nurses and activity instructors and there is always at least one staff member on duty.

[73] Unfortunately, McTavish Manor did not have a residential space available for Ms. Horn. Brent White, whose duties include managing McTavish Manor, indicated that there is always a waiting list for this facility, usually one to two people. Ms. Horn's total access to the program turned out to be five occasions during the two week period commencing September 23rd, 2003. She spent between three to five hours at the facility on each visit. On four occasions she helped prepare a meal, did some housecleaning and some other household chores. On the fifth occasion she accompanied staff from the manor to do some grocery shopping. Unfortunately Sharon Horn was terminated from the McTavish Manor program, apparently because of funding issues. Sharon Horn was a recipient of social assistance from the Province of Manitoba and the department that dispenses that assistance was not prepared to provide for her living expenses in one location and, in addition, provide funding for the expenses necessary (such as groceries)

to allow her to participate in the McTavish Manor program. As a result, after five sessions, Sharon Horn was no longer able to utilize this program which was the only structured program within the Mental Health System for clients to learn independent living skills.

[74] During her limited time at McTavish Manor, the staff did some assessing of Sharon Horn's "living skills". A 12 page assessment document called a Residential Service Living Skills Assessment was filed as an exhibit in this inquest. The document as it relates to Ms. Horn was only partially completed reflecting the fact that only some of the relevant skills were observed. The document allowed the assessor to note whether Ms. Horn could perform a function independently, do so with some prompting or cues, do so only with extensive instruction and/or assistance or could not perform the function at all. The document revealed that, of those functions assessed, those which Ms. Horn could perform independently without help were some of her grooming skills, her dressing skills, her social and interpersonal skills, and some very limited cooking skills. Many of the functions were not assessed including her money management skills and her ability to take her medication as prescribed without prompting. Although this document did contain some relevant information regarding independent living skills, it was obvious that the assessment completed was woefully inadequate at determining whether Sharon Horn was equipped to live independently. This is understandable considering the limited time which staff had to observe Ms. Horn at McTavish Manor. This was the only structured skill assessment ever done concerning Ms. Horn.

[75] In early October 2003, Ms. Horn raised with Gerald Isaac the possibility of obtaining her own apartment at a block called Armstrong Place. She had become aware of an upcoming vacancy for November 1st. Armstrong Place is a nine-unit housing facility where the occupants live completely independently. It is operated by its own board and is funded by the Brandon Regional Health Authority and by Manitoba Housing. The occupants of these housing units are clients of the Mental Health System.

[76] Mr. Isaac, in his evidence, disclosed that he discussed the Armstrong Place option with some of the other staff members at Community Mental Health. There was a mixed opinion as to whether Ms. Horn was capable of handling independent living. The consensus was that the best option for her was still some type of shared accommodation as this would involve more supervision and support. This was an arrangement acceptable to Ms. Horn but, unfortunately, Community Mental Health had been unsuccessful in making such an arrangement. Other options such as Manitoba Housing and senior's homes were also not available due to long waiting lists. Ms. Horn had few options and was aware that the apartment at Armstrong Place could only be held for her until about mid-October, resulting in some pressure on her to make a decision.

[77] On October 6th, 2003, Ms. Horn's bed at the Crisis Stabilization Unit had to be given up and she was moved to the YWCA residence. Ms. Horn was given her own room and received much of the same care she received in her previous placements in that

her meals were provided, her medication was dispensed and she received housekeeping services.

[78] The YWCA residence, however, was not viewed by Community Mental Health as an acceptable long term living arrangement for Ms. Horn as it was large, included both genders, was used to house recently released inmates, and had shared bathrooms which caused safety concerns.

[79] Around mid-October, a two bedroom suite in a senior's complex in Brandon became available. Gerald Isaac wanted Ms. Horn to consider this as an option as he still had apprehensions about her plans to live independently. Ms. Horn refused to consider this arrangement and it was not pursued further. Mr. Isaac indicated that he did not express his apprehension to Ms. Horn as he thought it might be "counterproductive" to her gaining the skills for independence. He believed independent living was what she wanted and he viewed it as a reasonable plan as long as she had continued proctor service and other supports.

[80] Mr. Isaac attempted to get Sharon Horn further training at McTavish Manor but was unsuccessful.

VII Independent Living

[81] Sharon Horn moved into her own apartment on October 31, 2003. Gerald Isaac helped her move and believed she was excited about having her own place. He observed no anxiety or apprehension on her part about the move.

[82] In order to assist Ms. Horn with her transition to independence, Mr. Isaac had arranged for increased proctor service commencing November 1st, 2003. Ms. Horn was allocated 15 hours per week with a proctor, an increase from eight hours. One of the documents filed in these proceedings was Mr. Isaac's internal request for the increased proctor hours. It is instructive to note that on this form, Mr. Isaac declares that Sharon Horn requires help or enhancement for virtually all skills related to independent living. Some skills such as banking and analyzing household safety issues would have to be learned and taught to her by the proctor.

[83] At the same time, a new proctor was hired for Ms. Horn, namely Joanne Didur. She had considerable experience as a proctor and was seen as a good fit for Ms. Horn, considering her age, her interests and her skill level. Ms. Horn was not asked to participate nor was she involved in the hiring of the new proctor.

[84] Ms. Didur started working on November 7, 2003, and met with Mr. Isaac. She reviewed with him the objectives of proctor support which were to maintain nutrition and household routines, provide reminders for appointments and medical routines including

medication, to assist with money management, and with the initial set up of the apartment. Her first task was to assist Ms. Horn in purchasing items for her apartment. At this meeting, Mr. Isaac outlined the nature of Ms. Horn's illness but there was no discussion of Ms. Horn's personality or any review of what activities or happenings may cause stress or what warning signs to look for if Ms. Horn was experiencing anxiety or distress. Ms. Didur, in her evidence, agrees that this information would have been helpful. Brent White, supervisor of the proctor program with the Brandon Regional Health Authority confirms that the proctor should be given the following information:

a) risk factors involved in the client (stressors);
b) symptoms of distress;
c) when and how to communicate with the mental health worker including the type of communication and what incidents should be communicated.

[85] According to Ms. Didur, none of this information was discussed with her by Mr. Isaac when she became Ms. Horn's proctor.

[86] Ms. Didur is described by Mr. Isaac as a dynamic, powerful individual who was very respectful of her clients and centered on their needs. She was also described as being very task oriented. When asked whether he had a concern about Ms. Horn having a proctor who was task oriented, Mr. Isaac acknowledged that it was something he had thought about. He told Sharon Horn that he would see how it went with the proctor. He

believed that Ms. Didur was the type of person to help Ms. Horn get established in her apartment.

[87] Ms. Didur had direct contact with Sharon Horn from November 10th until December 8th, 2003 for a total of 19.5 hours. She went to Ms. Horn's apartment on four occasions. She helped her purchase items for her apartment and accompanied her on other outings. She testified that Ms. Horn always seemed happy and she observed that there always seemed to be adequate food available in her apartment. She said the apartment was kept neat and there were no concerns about personal hygiene. On December 8th, when Ms. Didur visited Ms. Horn, she seemed very quiet and wasn't prepared to engage in any conversation. She was also not prepared to make any future plans with her proctor. Ms. Didur reported this to Mr. Isaac on December 12th, and he told her not to push the issue and to give Ms. Horn a little space. Ms. Didur had no further contact face to face with Ms. Horn. She attempted to contact her by telephone on three occasions unsuccessfully and finally reached her on December 22nd. She tried to set up an appointment but Ms. Horn said she was busy and didn't want to make any commitments to any future appointment. Ms. Didur reported this conversation to Mr. Isaac who told her to give Ms. Horn a break and they would try to reconnect after the holiday season.

[88] In the meantime, Mr. Isaac was starting to observe some problems and receive some complaints from Ms. Horn. In mid to late December, Mr. Isaac's notes revealed that he was becoming concerned about the number of changes that Ms. Horn was dealing

with and started encouraging her to slow down and take it easy. He testified that he viewed her move to independent living as a major transition for her and wanted her to experience change gradually. When he visited her on November 28th at her apartment, she seemed annoyed that a piece of furniture hadn't arrived. On December 1st, she told Mr. Isaac that she did not want to be intruded on too much. Mr. Isaac agreed that this conversation was a concern, as one sign of relapse for Ms. Horn was her desire to isolate herself. On December 4th, she told Mr. Isaac that she had a personal issue to discuss with him but he was unable to meet with her until December 16th.

[89] On December 16th, Ms. Horn expressed great discontent with her proctor, Ms. Didur. She said her proctor was rude, insulting and bossy. She didn't want any further contact with her. She wanted to be left alone. Mr. Isaac was concerned that she was withdrawing from an important support in the community and tried to encourage her to have further contact. In the meantime, Mr. Isaac had already spoken to the proctor agreeing that she could back off from her contact with Ms. Horn but, at the same time, assumed that some contact would continue. He, however, does not recall having any communication with the proctor after December 16th, 2003, and does not recall ascertaining what contact the proctor was having with Ms. Horn.

[90] Mr. Isaac last communicated with Sharon Horn on December 23rd, when he stopped by her apartment. She was on her way out so he was not able to visit with her for very long. His notes of this visit indicate that she "looked okay" but that she complained

of an upset stomach and "nerves in recent weeks attributed to too much reorganization". She reconfirmed that she wanted to be left alone and didn't want proctor service. Mr. Isaac testified that he did not agree with Ms. Horn that he would terminate proctor service but did agree that she should have a quiet holiday and they would discuss plans in the new year. Mr. Isaac was going on holidays and wouldn't be returning until January 2nd and told Ms. Horn he would call her when he got back. As it turns out, nobody from Community Mental Health had any communication with Ms. Horn from December 24th until the date of her death.

[91] We heard evidence from Debra Wright-Nantel, who is the community support worker with Community Mental Health. She had been successful in convincing Ms. Horn to become involved in numerous community activities. Ms. Wright-Nantel had regular contact with Ms. Horn until December 24th and, in fact, had seen her every day for 10 days prior to that date as they were both helping with the preparations for the Westman Traditional Christmas Dinner. On December 24th, Ms. Horn announced that she was not going to attend the dinner as she wanted to stay home. Ms. Wright-Nantel testified that she was not surprised by this decision and stated that Ms. Horn seemed fine and observed no signs of her health deteriorating. Ms. Wright-Nantel was also going away on a holiday which meant that another important community contact was no longer available to Ms. Horn. Ms. Wright-Nantel did not report to Mr. Isaac that she was going to be away on a holiday and suggested that this type of communication with the mental

health worker was not common. She also confirmed that she was never asked to monitor Ms. Horn's behavior or her attendance at programming.

[92] Jean Hoeppner, Ms. Horn's previous proctor, saw her downtown on December 26th, and indicated that they had a friendly conversation. Ms. Horn said that her stomach was bothering her but there was no other indication of any deterioration of her health. She did tell Ms. Hoeppner that she did not have a proctor in place, which Ms. Hoeppner attributed to the Christmas season.

[93] Myrtle Wooldridge spoke to her sister by telephone on December 27th and mentioned visiting Ms. Horn but no specific plans were made.

[94] There was no evidence of any other specific individual having contact with Sharon Horn from that date until her death.

VIII Circumstances Surrounding the Death of Sharon Horn

[95] At approximately 3:30 in the afternoon of January 2nd, 2004, Brandon Police Services received a call from an individual expressing concern about a pedestrian walking on Eighteenth Street in Brandon. The caller stated that she observed the person at 2:00 p.m. walking in the middle of Eighteenth Street (which has a median) and appeared to be walking in her winter coat and slippers. An hour later she observed the woman again walking further north on Eighteenth Street across the Eighteenth Street

Bridge northbound and suggested that she may be suffering from dementia. The Brandon Police Services dispatched a police unit to investigate and Cst. Gerald Paddock arrived at the area of the Eighteenth Street Bridge about 18 minutes after the original call was received. Cst. Paddock did not make notes of the incident but it was his belief that the woman had last been seen when the call was received by the police at about 3:30 rather than about 3:00 when, in fact, the caller indicated she had last seen her.

[96] Cst. Paddock searched the area driving northward on Eighteenth Street, under the bridge and then patrolled the surrounding streets, seeing nothing. After searching for about seven minutes in his vehicle, he checked into the police dispatch and learned that nothing further had been heard about the pedestrian and no further calls had been received. He checked with some workers at a gas bar just over the bridge and they had not seen anything. He searched for about another 10 minutes in the area, saw nothing of significance and terminated his search at five minutes after 4:00.

[97] At approximately noon on January 3rd, a person snowshoeing in a field in an area just northwest of the Eighteenth Street Bridge discovered a frozen body. The Brandon Police Services were called and one of the investigators who attended was Sgt. Shane Corley, who has 20 years of police experience and is supervisor of the Criminal Investigations Section. Sgt. Corley testified that he was dispatched to the scene at about 12:37 p.m. and ensured that the Identification Section were present and completed their job before the other investigators went near the scene.

[98] Cst. Klassen of the Identification Section of Brandon Police Services was called to the scene. He has been a police officer for 17 years and a member of the Identification Section for six years. He testified that it is his job to record the scene of a crime or an incident, seize any exhibits from the scene and coordinate what should be sent to the appropriate facility for analysis.

[99] Cst. Klassen arrived at 13:20 hours and noted that the body was just southwest of the intersection of Twenty-second Street North and Hilton Avenue. The emergency measures personnel had been there already and had taken the same path in to the body and out to reduce any tampering of the scene. There were no other tracks to the body although it had snowed the previous evening. The weather was extremely cold. We learned that on January 2nd, the high temperature had been -14.2 degrees Celsius and the low temperature was -23.4 degrees Celsius and on January 3rd, the high temperature was -18.1 degrees Celsius and the low was -33.5 degrees Celsius.

[100] Pictures of the scene were filed in evidence. They show that the body could not be seen from the street as there was a snow bank which hid it from view. Cst. Klassen testified that there were no signs of trauma or foul play. Her glasses were still on her face. It appeared that she had been leaning against a post and had slid down the post as hypothermia set in. Cst. Klassen observed condensation at the bottom of the post, which he considered being consistent with heat escaping from her body and evidence that she had died at that location. She was wearing a light winter parka, lightweight pants

similar to those worn in a hospital and woolen slippers and socks. One of her slippers was off and about five feet from her body. Her gloves were in her pocket which the Constable opined was consistent with the warm euphoria that people experience as hypothermia sets in. The body was located 67.8 metres from the intersection of Hilton Avenue and Twenty-second Street North and 59.8 metres from the closest home. The body was transported to the morgue and at that time identification was found on her which identified her as Sharon Joyce Horn. Later that day the body was identified by Ms. Horn's sister, Myrtle Wooldridge.

[101] The medical examiner for the City of Brandon, Dr. Charles Norman, gave evidence in these proceedings. He observed the body at the morgue and his first conclusion was that the clothing worn by the deceased was not adequate for the weather. He observed that she was wearing a lightweight jacket, lightweight pants and woolen slippers, all of which he considered inappropriate for the cold winter weather.

[102] He ordered an autopsy which included an unrestricted post-mortem examination which means that the internal organs are examined and analyzed. He did not personally perform the autopsy but used it to reach his conclusions.

[103] Dr. Norman testified that it is his role as a medical examiner to investigate the manner and cause of death. This is an expanded role beyond that of the pathologist who only determines the cause of death.

[104] He concluded firstly that the cause of death was hypothermia which is a subnormal body temperature. In describing hypothermia, Dr. Norman suggested that people that experience it often don't realize they are in trouble. They firstly become cold and uncomfortable and then become euphoric and actually feel warm, often removing clothing. In the case of Ms. Horn, the fact that her gloves had been taken off and were found in her pocket was consistent with someone experiencing hypothermia. Dr. Norman also concurred that the existence of condensation on the pole where Sharon Horn's body was lying was evidence that she had died at that location. He also stated that it was not possible to determine exactly when she had died.

[105] The police also conducted a search of Sharon Horn's apartment. The only items of significance which they located were blister packs of pills which were handed over to the medical examiner. These blister packs were for a one week period and all were full except for one, which only had the medication from the Monday having been consumed. This would suggest that Ms. Horn had last taken her medication on December 29th, and therefore missed five days including the day her body was located. Dr. Norman testified, as did Dr. Mano, Ms. Horn's psychiatrist, that not taking medication for five days would likely have little effect on her mental health. It would be safe to conclude, however, that the fact she was not taking her medication would be a sign that her mental health was deteriorating.

[106] Myrtle Wooldridge, Ms. Horn's sister, was given access to her apartment to go through her personal effects. She took home with her a laundry basket full of Ms. Horn's personal items. At the bottom of the laundry basket she found a note which read as follows:

GOOD
BY
EVERYONE
BECAUSE
2DAY
MAY BE
OVER WITH
I LOVE THE ONE
LIKE M (the remainder is illegible)

[107] This note was handed to the police and the original was filed as an exhibit.

[108] Three questions obviously arise from this note:

1) As the note was unsigned, who was the author?

2) As the note was undated, when was it written?

3) Was this a suicide note?

[109] As the note was located in Sharon Horn's apartment, it is safe to assume that she was the author of the note. The note was located under some items described as ornaments in a laundry basket which would suggest that it was not written that day. Otherwise, there is no way of determining when it was written. The note itself has the tone of a suicide note but may also be an expression of resignation or frustration with the

life the author (Ms. Horn) was leading. The fact that the note was not located in a conspicuous spot would also militate against the note being intended to be read on the date of her death.

IX The Death of Sharon Horn – Suicide or Misadventure?

[110] The evidence is clear that Sharon Horn died from hypothermia. Her body was found in an open field on the edge of the City of Brandon on a day when the temperatures reached below -30 degrees Celsius.

[111] There was no reason to suspect foul play and no indication that anyone else was involved with her death. The police investigation and the autopsy confirm these conclusions.

[112] The known facts surrounding her death point to at least three possible theories as to the cause for her behavior:

1) She intended to commit suicide;
2) She was experiencing a psychotic episode or some extreme anxiety related to her mental illness that caused her to misapprehend the danger of being outside so was inadequately dressed;
3) She was out walking and merely lost her way, ultimately panicked and ended up somewhere where she could not get help.

[113] There are many elements to Ms. Horn's life that would support the theory that she committed suicide. Ms. Horn suffered from schizophrenia which brings with it a high suicide rate. She had threatened suicide when she was a young woman and had recently made statements to her mental health worker which he recorded as "passive suicidal" comments. She had never strayed this far from home before and had never seemed to get lost, which might suggest she deliberately went to where she ended up. The other factor supporting suicide is the note that was found in her apartment which, on the face of it, has the tone of a suicide note.

[114] The factors that militate against suicide are also numerous. The note that was found was discovered at the bottom of a laundry basket and was obviously not placed in a conspicuous location as one would expect. It therefore may not have been intended as a suicide note or may not have been recently written. Ms. Horn had never made any previous attempts to commit suicide and had not made a direct threat to do so for over 30 years. All those who worked with her in the health care field did not believe that she would commit suicide including her psychiatrist and her present and past mental health workers. Nobody detected any overt signs of depression that would typically be evident prior to someone taking such drastic action. Her sister, Myrtle Wooldridge, also does not believe that Ms. Horn committed suicide.

[115] The description of Sharon Horn as provided by the caller to the Brandon Police Services on January 2nd also does not support suicide. Walking down the street

inappropriately clothed is more consistent with someone who is disoriented rather than on a mission to take her life.

[116] The more likely options are that Sharon Horn was either lost and became disoriented or that she was suffering from an acute episode or extreme anxiety related to her mental illness. There were some signs that had been observed that were consistent with her mental health deteriorating. She had taken steps to withdraw socially which is the most common symptom of a relapse from someone suffering from schizophrenia. We heard evidence that she had severed her connection with the proctor and had not been interested in attending a social event which she would typically attend.

[117] Ms. Horn had also embarked on one of the most challenging and stressful endeavors of her life; living independently. There is ample evidence to suggest this was occurring when she may not have been ready for such a step. Her psychiatrist testified that attempting to do more than she was capable of could certainly cause her stress and could trigger a relapse of symptoms. None of her health care supporters had any contact with her for approximately 10 days prior to her death and it is certainly conceivable that she could have become more and more anxious during that period to the point where she lost her grip on reality. In this state she may have headed out, improperly dressed, become disoriented and not had the presence of mind to seek help. This scenario is more consistent with the observation of Ms. Horn on Eighteenth Street, walking down the middle of the road, appearing to the caller to be suffering from dementia.

[118] The evidence that Ms. Horn had not taken her medication for five days also points to a conclusion that she may have been experiencing some mental health deterioration.

[119] At the end of the day, we are left with the conclusion that there is no way of determining with any certainty what caused Sharon Horn to do what she did on January 2, 2004. Adopting any of these theories or any other would unfortunately be little more than pure conjecture and the answer to this question will likely never be known.

X The Role of the Brandon Regional Health Authority and Brandon Police Services

[120] The *Fatal Inquiries Act* directs that a written report be prepared,

> A setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of their death.

[121] The Provincial Judge,

> May recommend changes in programs, policies or practices of the government and relevant public agencies or institutions or the laws of the province where the presiding 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.

[122] In doing the above the Judge,

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

[123] In fulfilling the responsibilities set out in the *Act*, it is necessary to analyze the practices of both the Community Mental Health section of the Brandon Regional Health Authority and the Brandon Police Services as they relate to the circumstances surrounding the death of Sharon Horn.

[124] Counsel for the Brandon Regional Health Authority submitted that, if I am unable on a balance of probabilities to conclude the circumstances which lead to the death of Ms. Horn, I am precluded from or unable to make recommendations that could reduce the likelihood of such further deaths occurring. He argues that if I can't conclude what was done or not done to contribute to the death, how can I recommend changes to practices which may have had nothing to do with her death.

[125] I don't accept this proposition. The scheme of the *Fatal Inquiries Act* is to establish an inquiry for purposes of improving the practices and procedure of government or public agencies and institutions without attributing blame. The inquiry is not focused on culpability but facilitating change. For that reason I find that Section 33(1) of the *Fatal Inquiries Act* should be read disjunctively and that the inquiry Judge should be free

to make recommendations even if the circumstances surrounding the death cannot be determined on a balance of probabilities.

The Regional Health Authority

[126] Sharon Horn had been a "client" of the Mental Health System for most of her adult life. She had, from 1970 until November of 2003, lived in a licensed residential care home which was licensed and supervised by Community Mental Health. Although Sharon Horn was never declared mentally incompetent, and was therefore free to make her own care decisions, the evidence disclosed that, because of her personality and her intellectual limitations, she had always lived in circumstances where decisions relating to her care were effectively made by others.

[127] Until September of 2003, most of her needs were met by care providers. She had expressed no desire to take on more responsibility for her own care or to live independently.

[128] In September 2003, she was removed from her residential care placement in circumstances that did not relate to her care. I am not in a position to second guess the basis for the decision to remove her from this home but certain facts are obvious:

a) the decision was made without giving the caregivers any opportunity to present their version of events;

b) the decision was made without consultation with Sharon Horn or even her mental health worker;

c) the decision was made with little or no thought or planning as to where Sharon Horn might next live.

[129] It was conceded by the Regional Health Authority that Ms. Horn and her mental health worker should have been involved in this decision. The mental health worker is the individual who is working closest with the client and is ultimately saddled with the responsibility of facilitating the securing of another appropriate place for the client to live. In the recovery model of treatment, the client is a full participant and theoretically the director of treatment plans and, as such, certainly should have been involved in such a dramatic decision. This is particularly so since there was no evidence of any threatened imminent harm to Ms. Horn had she remained in that home for a further period of time.

[130] Once Ms. Horn was removed from residential care, the representatives of Community Mental Health point out that it was her idea to live independently, that she pushed for that option and found the place where she wanted to live. What seems equally clear is the following:

a) Sharon Horn was receptive as well to living in more supportive environments such as another residential care placement or shared accommodation with other mental health patients in a proctor supported environment;

b) She is an individual who likely could have been convinced to delay her move to independent living until she had acquired more skills to assist her;

c) She would rely on others to determine whether she was ready to live independently and would unlikely be able to assess this for herself;

d) That, although Ms. Horn had the right to make decisions concerning her living arrangements, the particular relationship between Ms. Horn and Community Mental Health was such that there was at least an expectation that all steps would be available to ensure that her decision was the appropriate one and supports were in place and being utilized to ensure a successful transition;

e) It should also be remembered that the idea of Sharon Horn living independently was consistent with the recovery model of treatment in that Ms. Horn would be expanding her skill level, would be less reliant on others, and this would in theory, enhance her self-esteem. Independent living would allow her to escape the "stifling environment of residential care" where there is little or no emphasis on personal growth.

[131] This then leaves us with the three questions posed in the introduction to this report:

a) Was Sharon Horn capable of living independently?

b) Was she properly prepared to do so?

c) Were appropriate supports in place to allow her to succeed and were they being utilized?

A: Was she capable of living independently?

[132] All of the evidence from the caregivers at Community Mental Health support the proposition that she was capable of living independently. Dr. Mano, her psychiatrist, opined that Ms. Horn had the capability of more independence if she was exposed to some skill training and had the proper supports in place. Debbie Wickstrom, Ms. Horn's former mental health worker, was also of the view that Sharon Horn was capable of much more than she had been able to demonstrate in the past and supported the concept of her living independently.

[133] Myrtle Wooldridge, Ms. Horn's sister, testified that she did not think Sharon was capable of looking after herself. Her opinion seemed to be based, however, on how she saw Sharon functioning and not how she was capable of functioning. Her concerns were about Sharon's lack of living skills, not whether she was capable of learning them.

[134] Based on the evidence presented there is no reason to conclude that Sharon did not have the capability of more independent living.

B: Was she properly prepared?

[135] When Sharon Horn was removed from residential care, she had few skills necessary to live independently. She had participated in some meal preparation though a weekly program at a local church. We heard evidence, however, that this was in no way geared towards independent living but consisted of such rote tasks as peeling onions and

washing a pot. Other than these few skills, Sharon Horn had never received any preparation geared towards living on her own. She had always had her basic needs provided for her by caregivers. She had never performed everyday tasks such as preparing meals on her own, laundry, grocery shopping, et cetera. While at the Crisis Stabilization Unit she was shown how to use the laundry facilities and seemed to be capable of operating those machines. She was also responsible for reporting to staff when she was required to take her medication and seemed to be aware of when her medication was due.

[136] Ms. Horn then had five sessions at McTavish Manor, which is the only skill-teaching and assessment facility available with Community Mental Health. We were told that she did some meal preparation, some house cleaning and went grocery shopping on one occasion. It was acknowledged by her mental health worker that more skill training would have been beneficial but McTavish Manor was not available because of a funding issue related to her social assistance.

[137] An assessment was completed at McTavish Manor which was marginally useful. Many of the necessary living skills were not observed by staff because of the limited time to observe Ms. Horn and also because she was not residing at the facility. The assessment also revealed that many of the skills outlined were ones that Ms. Horn could not perform without assistance or prompting.

[138] Dr. Mano testified that her endorsement of Sharon Horn living independently was based on her being taught the skills necessary to do so and an appropriate assessment being completed to determine if she had acquired those skills. It is evident that this did not happen. Sharon Horn had little opportunity to learn the skills she required because a shortage of space prevented her from becoming a resident of McTavish Manor and a funding problem prevented her from using the services to any significant extent as a non-resident.

[139] In answer to the question as to whether Sharon Horn was prepared to live independently, one would have to say the answer is “we don’t know”. In spite of evidence to the contrary from representatives of the Regional Health Authority, the inevitable conclusion is that Community Mental Health could also not know whether she was ready to live independently as she had never been properly assessed for that purpose.

C: Were appropriate supports in place to allow Ms. Horn to succeed with living independently and were they being utilized?

[140] It was essential to Ms. Horn successfully making the transition to independent living that appropriate supports be in place. It was also crucial that these supports be utilized as Ms. Horn had a history of withdrawal from social interaction if her health was deteriorating.

[141] The supports in place for her as arranged by Community Mental Health were regular contact with her mental health worker, regular programming through a community support worker and regular contact with and assistance from a proctor. The evidence is that Gerald Isaac, the mental health worker, had regular contact with Ms. Horn until he left on holidays on December 23rd. Likewise, Debbie Wright-Nantel saw Ms. Horn often until she also left on holidays commencing December 24th.

[142] We heard evidence that the proctor hours were increased to 15 per week as this was deemed to be the support necessary for Ms. Horn in her new environment as determined by Community Mental Health. In the period from November 10th to December 8th, Ms. Horn saw her proctor for a total of 19.5 hours, an average of five hours per week. Ms. Horn then cut off any contact with the proctor and did not have any direct contact with her again. The mental health worker was made aware that Ms. Horn did not like her proctor and did not want a replacement. Mr. Isaac decided not to push the matter and allowed Ms. Horn some space and time to be alone. As a result she was without proctor support from December 8th to the date of her death.

[143] This decision, in retrospect, seems unreasonable and completely contrary to the service plan for Ms. Horn. It is evident that an important component of her transition to independent living was the support of a proctor. Mr. Isaac also confirmed in his evidence that he was concerned that the new proctor and Ms. Horn were not a good fit. While recognizing that Ms. Horn had the right to refuse proctor services, it is suggested that

more pressure should have been applied to Ms. Horn to resume contact with her proctor or a new proctor should have been introduced to see if that would make a difference. Considering the major changes occurring in Ms. Horn's life, the stress that that would obviously cause her, and her tendency to withdraw when suffering a relapse, the decision to leave her without proctor service for that length of time without exploring some other options is not defensible.

[144] The answer to the last question is that appropriate supports seemed to be in place but were not being utilized.

Brandon Police Services

[145] A person who we now believe to be Sharon Horn was observed by a passing motorist who saw her walking down Eighteenth Street in Brandon. The motorist was concerned enough to call Brandon Police Services (BPS) and attempted to call at approximately 2:00 p.m. She apparently called the main business line of BPS as opposed to the 9-1-1 emergency line and was unable to get through. She was uncertain whether she received a busy signal or a message. Approximately an hour later, the same caller was again traveling on Eighteenth Street and once again saw the same individual, this time walking northward over the Eighteenth Street Bridge. This bridge consists of a lengthy span traveling over the main railway line which travels through the City of Brandon and Eighteenth Street is one of the busiest thoroughfares in the City.

[146] The concerned citizen again called the main business line and got through at 3:29:39 p.m. A transcript of the call was available and reads as follows:

> BPS: Good afternoon, Brandon Police Service
>
> C1: Yeah um, I am calling in regards to, I was going, driving along Eighteenth Street at two o'clock, and there was a large Native woman, um, in the middle of Eighteenth Street with their winter coat and slippers on, and I didn't think anything of it, well an hour later when I'm driving back on Eighteenth Street, same woman, but now she's on the bridge, or was on the bridge.
>
> BPS: On the Eighteenth Street Bridge?
>
> C1: Um, yes, still with her slippers, she's been out in the snow, you know, at least since two o'clock when I saw her and had tried phoning earlier from IGA, that's where I was headed but I couldn't get through so now I'm getting through.
>
> BPS: Eighteenth Street so she's northbound
>
> C1: Uh that's the direction she was going, so she didn't go very far in the hour but like I said, nothing but a winter coat and her slippers on so she's either, you know, with dementia or whatever
>
> BPS: Okay, we'll get a call and have the guys check it out.
>
> C1: Thanks, thanks bye bye
>
> BPS: Bye bye.

[147] Calls which BPS receive on their main line are handled by call takers referred to as front desk attendants. The attendant's job is to receive the information from the caller, input it into a computerized aided dispatch system and forward it to the dispatch unit. It is then the responsibility of the dispatch unit to assess the availability of police officers and dispatch the appropriate officer to the location. It is also the task of the front desk attendant to categorize the incident reported based on its urgency, and, depending on the category selected, the matter will be given a priority. Incidents reported have three levels of priority: red, being the highest priority; yellow, being the middle; and green, being the lowest. The attendant has a manual which automatically categorizes the urgency of the call based on its subject matter, but the attendant has the discretion to upgrade the priority or increase the urgency of the response if the attendant believes that to be appropriate.

[148] The attendant who received the call in this case categorized the incident as a reported suspicious person (which seemed to be the only possible category of those available to her) and, as a result, this matter was given a yellow or mid-range priority. The attendant forwarded the incident report to dispatch and we were told that this was done in one minute and 44 seconds. The information sent to dispatch was as follows:

> Rpts a very large native female, northbound on 18th St wearing a winter coat and slippers. She was walking down the middle of 18th St. When caller was headed back in that direction, she advises that this female is

> now on the 18th St bridge, northbound. She is quite concerned for her well being.

[149] When dispatch received the call, there was no police unit immediately available as most were involved with other matters such as traffic accidents and one officer, Cst. Paddock, was still on his lunch break. As this was categorized as having a mid-range priority, in accordance with policy, no police units were redirected to respond to this call and Cst. Paddock was not taken off his lunch break. He was, however, almost finished lunch and was dispatched at 15:36:51, which was just over seven minutes from when the original call was received. This is the information given to Cst. Paddock from the dispatch unit:

> Police Unit 109 (pause) can you do an extra patrol in the area of Eighteenth Street Bridge, I have a report of a large Native female northbound on Eighteenth Street. She's wearing a winter coat and slippers. At one point in time she was walking down the middle of the street, and when we got the call about, seven minutes ago, she was on Eighteenth Street Bridge northbound. So if you could do an extra patrol for us?

[150] Cst. Paddock arrived at the Eighteenth Street Bridge at 15:54:31, just under 15 minutes from the time the original call was received. Cst. Paddock conducted his search and, as described earlier in this report, was unsuccessful in locating the person described. He discontinued his efforts at 16:05:22, about 36 minutes after the call was first received by BPS.

[151] In reviewing the involvement of BPS on January 2nd, 2004, certain questions arose which were reviewed during this inquiry:

a) The concerned citizen who called BPS at 2:00 p.m. indicated that she may have received a busy signal. Does BPS have an appropriate system in place to ensure, within reason, that people do not receive busy signals when they telephone the police?
b) Was the information received by the front desk attendant and ultimately conveyed to the police officer who conducted the search accurate or sufficient?
c) Was the categorization of this incident as a mid-range priority reasonable in the circumstances?
d) Was the search conducted by Cst. Paddock adequate considering the information he was given?

[152] We were told that the concerned citizen phoned the main police line at 2:00 p.m. on January 2nd, 2004, and could not get through. She was uncertain whether she received a busy signal or a message giving her the option of calling the 9-1-1 emergency line. Obviously, it raises a concern if she did, in fact, receive a busy signal. All reasonable steps should be taken and systems put in place to ensure that as seldom as possible, a person does not receive a busy signal when telephoning the police.

[153] We were told that on January 2nd, 2004, the BPS main line telephone system had capacity to handle five calls without receiving a busy signal. The second to fifth

callers would receive a message asking them to hold or to call the 9-1-1 line. The sixth caller would receive a busy signal. We were also told that the main line of BPS received 67 calls between 2:00 and 4:00 on the date in question and that this was considered to be a busy time. This number of calls obviously raises the possibility that the caller may have received a busy signal when she first called. It seems evident that, if the caller had been able to complete her call at 2:00 p.m. when she first called, it is likely that the person on Eighteenth Street would have been found.

[154] BPS has apparently now added a feature to their main line phone system which has added a further mailbox of three callers. This essentially gives callers seven through nine in line a message to call 9-1-1 or call back but unfortunately does not give them the option of holding to speak to the front desk attendant.

[155] A review of the call transcripts reveal that the front desk attendant did not pass along certain information to the dispatcher which had been provided to her by the caller. Specifically the following information was not conveyed:

a) that the caller had first seen the woman about an hour and a half before the call was received by BPS;
b) that she had last seen her about 40 minutes ago;
c) that she seemed to be suffering from dementia.

[156] Those witnesses who testified on behalf of BPS agreed that information about when the person was last seen was important information that should have been conveyed to the officer. The nature and extent of the search may have varied had the officer been given this information. As it was, he was lead to believe that this person had been seen about seven minutes from the time he was dispatched when, in reality, it was approximately 37 minutes. While this may or may not have resulted in a more extensive search, the officer would certainly have been made aware that the person could have traveled a greater distance since she was last seen.

[157] It would also seem that information that the person had seemingly been in distress for at least one and a half hours in extremely cold conditions may have raised the level of concern about the incident. The dispatcher may had decided to upgrade the priority or the officer may have conducted a more extensive search. The officer should have been given this information so he could make an informed assessment of what course of action was reasonable.

[158] There was also no information passed along to the officer that the person seemed to be experiencing signs of dementia. Witnesses from BPS testified that this type of information would typically not be passed along to the officer as this was not a fact but only the opinion of the caller. It would seem relevant, however, that the person was disoriented and in distress and should have, once again, affected the urgency of the situation.

[159] It is also standard policy of BPS that when an officer is dispatched, he is informed of the priority of the call to which he is responding. This was not done in this case which was something that should have been done. Cst. Paddock, however, gave evidence that he treated this matter as a yellow or mid-range priority call which was what he considered appropriate.

[160] The fact that these omissions occurred in the information conveyed to the officer resulted in some questioning about the training received by front desk attendants and by dispatchers. It was noted that the front desk attendants are employees of Brandon Police Services while the dispatchers are employees of the Fire Department and, as such, receive different training. The front desk attendants train on the job and their initial training is to shadow a front desk attendant for five weeks. Thereafter, they attend workshops and courses as they are offered.

[161] The dispatchers, on the other hand, are given two to three weeks of classroom training before they commence their duties which includes one week of call taking training. This includes work on communication skills and generally handling callers.

[162] No explanation could be offered as to why the front desk attendants do not receive this same training as dispatchers, in spite of the fact that they are performing the same duties. We were told that BPS is now requiring their new front desk attendants to complete the same communication and call taking training as the dispatchers.

[163] It should be noted that the front desk attendant who took the call on January 2nd, 2004, had 13 to 14 years experience.

[164] This call was automatically labeled as a suspicious persons call which results in a mid-range priority. As also noted, this meant that no other police units were redirected to attend this matter nor was an officer taken off his lunch break, resulting in a delay of about five minutes. We were also told that because this was a call of medium priority, the officer had the discretion to utilize his siren and flashing lights to get the scene faster. The officer in this case chose not to do so.

[165] In the circumstances, it is difficult to second guess the categorization of this matter as a mid-range priority. Considering the range of calls that police receive, requiring different urgency and response, a call about someone walking in the cold, even in some range of some kind of distress, was reasonably considered of medium priority. It should also be noted that the police only received one call about this individual in spite of the fact that she was walking down the median of a busy street in apparent distress and was apparently walking down this same street for over an hour. We heard evidence that the fact that only one call was received regarding this incident would have been a factor in it remaining as a mid-range priority call. It is a sad comment that of the hundreds and perhaps thousands of vehicles that passed Ms. Horn on that date, only one person took the time and interest to telephone the police. Whatever the reason may be for only one

person making such a call, whether it be not knowing what to do, expecting someone else to act or general apathy, it is a sad comment on our community.

[166] The officer dispatched to the scene was Cst. Gerry Paddock, an experienced officer with over 35 years with the Brandon Police Services. Although he took no notes, he was able to describe his search route in detail. He did not leave his vehicle to search for the subject individual but drove through the area at a slow speed looking for any sign of this person either walking or on the ground. The officer searched all of the area immediately surrounding the Eighteenth Street Bridge and made inquiry at a gas station close by. The Constable searched for approximately 11 minutes and he was allowed to complete his search without being directed elsewhere.

[167] There are no guidelines provided to officers in these circumstances and they are expected to use their best judgment as to what type of search is reasonable. Obviously, in this case it was reasonable to assume that the person sighted may have been picked up by a car or, alternatively, may have arrived safely at her destination.

[168] There was some suggestion that if the officer had been given more information about the length of time the subject had been out in the cold, other search methods might have been utilized such as a search dog.

[169] Sgt. Corley gave evidence, however, that in his opinion, a search dog would be of little assistance at that location as it would be unable to pick up any scent in such a highly congested and heavily trafficked location. Sgt. Corley also gave his opinion that the search conducted by Cst. Paddock was thorough and entirely reasonable in the circumstances. There is no evidence to suggest otherwise.

XI Assessment and Recommendations

Brandon Regional Health Authority and Community Mental Health

[170] We heard much evidence in this inquest from and about the Community Mental Health department of the Brandon Regional Health Authority. Two obvious conclusions can be arrived at from this evidence. Firstly, the employees of Community Mental Health who gave evidence in this inquest are caring, dedicated individuals who are committed to providing the best service possible to their clients. All the caregivers involved with Sharon Horn wanted what was best for her and were all, without exception, deeply affected by her death. Secondly, the evidence is clear that the level of mental health services in Brandon are considered to be extensive and superior to most of the rest of Manitoba. The reason for this enhanced service is likely because Brandon was the location of a mental health institution and, when it was closed, many of its patients remained in the community. Brandon has therefore benefited from this enhanced service available to those people in our community who suffer from mental health illnesses.

[171] Recognizing the above, it is evident that Sharon Horn did not receive the level of service that she was entitled to from her care providers. Decisions were made regarding her care without the resources to support those decisions or, alternatively, with resources available and not being utilized.

[172] The goal of any mental health system is to enhance the lives of its clients and to provide them with the tools to function in society at an optimum level. The recovery model of treatment involves a right to and promotion of the highest level of independence that a client is capable of achieving. It is important, however, that in striving for such a worthwhile goal, that those working within the system are ensuring that the resources are available and in place before the independence component of the treatment model is implemented.

[173] It is evident that what happened in the case of Sharon Horn was that the move to independent living was made at least partially because there were no other acceptable, viable options for her. Her move to independence was made in circumstances where resources were either not available or not utilized to ensure a successful transition period. The evidence would suggest that Sharon Horn was not properly trained nor appropriately assessed to determine her skill level to live independently before she was removed from a residential care placement. Although the decision to live independently was hers, it was not made in an environment where she had options that arguably were more appropriate.

The move to live independently was tacitly and perhaps even overtly endorsed by and facilitated by Community Mental Health.

[174] Once a decision was made that Ms. Horn would live independently in the community, resources were put in place to assist and supervisor her but were not utilized. This was obviously an important component missing in her successful move to more independence. The fact that nobody from Community Mental Health had any contact with Ms. Horn for a period of about ten days prior to her death at such a high risk time period was unfortunate and not appropriate. This gap in service was due to problems with communication between care providers and lack of a specific service plan during this risky transition period.

[175] The recovery model of treatment is a progressive concept but can only succeed if resources are made available and utilized. The following recommendations are suggested to improve and enhance the provision of services to mental health patients (noting that some have already been implemented):

1) **Community Mental Health develop a clinical practice guideline establishing protocols for all clients who are moving into a more independent living arrangement. The protocol should involve the following directives:**
    a) **That decisions made to change the living arrangements of a client and, in particular, to remove a client from a residential care placement should not be made without consulting with and taking**

into account the wishes of the client. The only exception would be when a client's personal safety requires the immediate removal of a client from a living arrangement.

b) That a move from a residential care placement to an alternative living arrangement which involves more independence involves inherent risk. This decision should not be made without consulting the mental health worker assigned to the client and, where applicable, the client's treating psychiatrist.

c) That the client should also, whenever possible, participate in any planning or discussion amongst mental health caregivers regarding potential changes to living arrangements.

d) That prior to any decision being made to increase the level of independence of a client's living arrangement, a full assessment should be conducted to determine the client's functional skills, cognitive abilities and mental health status to determine the level of risk in the proposed move. A standardized assessment process should be developed for this purpose and a component of the assessment should determine what skills may require further enhancement before the proposed change can occur.

e) That whenever possible, the client not be moved into a more independent living arrangement until the skills required for more

independent living have been developed sufficiently so that the risk involved with the move can be justified.

f) That unless the client's personal safety or wellbeing is at risk, the client should not be removed from a residential care placement unless there exists an appropriate long care alternative living arrangement which is immediately available.

2) Communication between the various caregivers involved with mental health clients needs to be improved generally but particularly during the time of residential transition. A structured case management process needs to be developed with the following components:

a) The mental health worker should lead the case management team and ensure that there is regular communication between all caregivers and collateral resources involved with the client.

b) All caregivers should be made aware of all the risk factor and warning signs specific to the client which might signal deterioration in mental health. All available resources should be utilized to watch out for and manage those risk factors.

c) Regular meetings of all caregivers should be encouraged to monitor and exchange opinions as to the status of the transition process. If possible, the client should be involved in such meetings.

3) That programming should be developed to enhance the independent living skills of those clients presently in residential care placements. This

programming should be made available to those clients who could potentially increase their self-sufficiency within a residential care placement or potentially acquire enough skills to move to a more independent living arrangement. This programming should be made available to all clients who might reasonably benefit from it and those clients should be actively encouraged to participate. Such a program should ideally include the training of existing residential care givers who could provide some of the skill development for the clients.

4) **That a variety of housing opinions have to be made available for mental health clients. These options should be sufficiently flexible to adapt to the client's needs and would include options from a completely supervised living arrangement to supported independent living. The options should also include short term living arrangement to allow clients to move gradually into a more independent environment and would also allow return to a more supervised environment should that need arise.**

5) **That the residential care system or a similar form of supervised living continue to be made available for mental health clients, when appropriate. Resources should be dedicated to these placements to encourage existing and potential caregivers to participate by providing a reasonable stipend for becoming a residential care provider and to train that individual to be able to assist the client in enhancing independent living skills.**

6) **That a mentoring system be developed to allow clients considering more independent living or actually making such a move to be matched with another client of the mental health system who can be available to offer advice and assist with the transition.**

7) **That the Provincial Government should ensure that any financial impediment which would prevent a mental health client who is on social assistance or some other form of public support from accessing non-residential independent living skills training be immediately removed.**

8) **That mental health workers and other care giving personnel within the mental health system be specifically trained as to how to respond to clients who are making decisions relating to their living arrangement that may result in safety concerns.**

9) **That a policy be adopted that, whenever possible, changes to health care personnel (such as a mental health worker or proctors) working with a mental health client be avoided during times of transition into a living arrangement which increases the inherent risk to the client.**

10) **That resources be dedicated to allow and encourage the families of mental health clients to be educated about the mental illness of their family member. This should be particularly encouraged in circumstances when contact with family is seen to be a cause of stress or possible mental health deterioration for the client. As much as possible the family should be**

educated and involved in the treatment plan for the client while still maintaining the client's wishes and right to privacy.

11) **That resources should be available to educate the general public about mental health to help create a community that is safe and receptive to people suffering from mental illnesses. An informed public might be more prepared to become involved if they see a person apparently suffering from mental health symptoms who is in distress.**

Brandon Police Services

[176] The following recommendations are made to enhance the call taking processes in place at Brandon Police Services and their response to calls involving possible mental health patients:

1) **That the Brandon Police Services should improve their phone system to ensure, as much as is reasonably possible, that a person who makes a call to Brandon Police Services does not receive a busy signal or is not required to phone back.**
2) **Front desk attendants should receive at least the same call taking training as dispatchers employed by the Brandon Fire Department who are performing the same duties.**
3) **That in circumstances where call takers receive information about individuals being out in extreme weather conditions, they should be trained to illicit from the caller any information available as to how long the person**

has been outside and that this information be passed along to the police officers who will be responding to the call.

4) **That police officers be directed that when they are searching for someone in extreme weather conditions, they have the authority, in appropriate circumstances, to utilize the media to alert the public and engage their assistance in locating the individual.**

5) **That the employees of Brandon Police Services should receive regular training and information on mental health awareness to assist in responding to calls involving citizens with apparent mental health issues.**

[177] I respectfully submit my recommendations and conclude this report this 8th day of June, 2006 at the City of Brandon in the Province of Manitoba.

EXHIBIT LIST

EXHIBIT	DESCRIPTION
1	Copy of letter of Chief Medical Examiner dated June 1, 2004
2	Photos taken by Cst. Klassen (56 photos)
3	Original note re: Sharon Horn
4	Transcript of dispatch calls dated January 2, 2004
5	Transcript of call to BPS dated January 2, 2004
6	Two print out of the CAD
7	Policy Chapter A Communications
8	Agreed statement of Mr. and Mrs. Burnett
9	Report of medical examination
10	Autopsy report form
11	St. Boniface General Hospital lab
12	DPIN Dispensing history
13	Memo from Albert Hajes
14	Adult day treatment planning review with Dr. Mano’s notes
15	Sharon Horn’s Community Mental Health file
16	Three pictures of house warming
17	Statement of Myrtle Wooldridge
18	Letter dated May 2002 – Sharon Horn
19	Letter dated June 10, 2002 – Sharon Horn

20 Letter dated July 2002 – Sharon Horn

21 Letter dated October 2003 – Sharon Horn

22 Letter dated November 2003 – Sharon Horn

23 Letter dated December 2003 – Sharon Horn

24 Pink scribbler – notes by Wooldridge

25 2004 Calendar – Sharon Horn

26 Five pages of photographs – Sharon's apartment

27 Coil notebook – Sharon Horn

28 Meditation prayer book – Sharon Horn

29 Rent receipt – October 1, 2003

30 Bundle of nine receipts from various stores

31 Three rent receipts

32 MTS bills

33 Card from Debbie Wright-Nantel

34 Lease for rental storage space from Spare Closet

35 Photograph with Shirley Ann taken December 24

36 Photo of 55th birthday – September 12, 2001

37 Brandon Regional Health Authority – January 2000

38 Christmas card to Gerry Isaac from Sharon Horn

39 Crisis Stabilization Unit file on Sharon Horn

40 Proctor Services policy and procedure manual binder

41 Community Mental Health program proctor services

42 Proctor file

43 Reference card

44 List of courses taken by Candace D’eathe

45 Index

46 FDA Training schedule

47 BPS front desk training evaluation

48 Package of three documents (Chief CAD printout, graph)

49 Incident report

50 Index of training manual

51 Flex hour

52 Public safety dispatcher

53 Unit status at time of call

54 Notes

55 Organizational chart

56 Clinical practice guideline for mental health programs

57 Letter of S. Corley dated December 21, 2005

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