RELEASE DATE: May 29, 2015

Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **FRANK ALEXANDER**
(DOD: MARCH 28, 2011)

Report on Inquest and Recommendations of
Judge Michel Chartier
Issued this 26 day of May 2015

APPEARANCES:

MR. PAUL COOPER AND MS MANDY KLEIN, Inquest counsel
MR. BILL GANGE AND MR. DAVID CORDINGLEY, Counsel for Alexander Family
MR. DAN RYALL AND MS CATHERINE TOLTON, Counsel for the Winnipeg Regional Health Authority
MS TRACEY EPP, Counsel for Parkview Place Care Centre
MS KIMBERLY CARSWELL, Counsel for the Winnipeg Police Service
MR. JIM KOCH, Counsel for the Manitoba Department of Health

RELEASE DATE: May 29, 2015

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: FRANK ALEXANDER

Having held an inquest respecting the said death on January 20, 21, 22, 23, 24, April 14, 15, 16, 17, October 27, 28, 29, 30 and November 6, 2014 at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: FRANK ALEXANDER.

The deceased came to his death on the 28th day of March 2011 at the City of WINNIPEG, in the Province of Manitoba.

The deceased came to his death by the following means:
Blunt head trauma (homicide)

I hereby make the recommendations as set out in the attached report.

Attached hereto and forming part of my report is a list of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 26 day of May, 2015.

"Original Signed by:"
Judge Michel Chartier

Copies to: Dr. A. Thambirajah Balachandra, Chief Medical Examiner
Chief Judge Ken Champagne, Provincial Court of Manitoba
The Honourable Gord Mackintosh, Minister of Justice
Ms Donna Miller, QC, Deputy Minister of Justice
Ms Jacqueline St. Hill, Director of Prosecutions
Mr. Paul Cooper and Ms Mandy Klein, Inquest counsel
Ms Kimberly Carswell, Counsel for the Winnipeg Police Service

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: FRANK ALEXANDER

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Paragraphs

I. THE CALLING OF THIS INQUEST

[1] The Chief Medical Examiner for the Province of Manitoba, Doctor A. Thambirajah Balachandra, sent a letter bearing date October 16, 2012 to the Chief Judge of the Provincial Court directing that, in accordance with *The Fatality Inquiries Act* (the "*Act*"), an inquest be held into the death of Frank Alexander for the following reasons:

1. to determine the circumstances relating to Mr. Alexander's death;

2. to ascertain whether there are adequate resources and facilities, and appropriately trained staff in Manitoba to manage long term care residents with Alzheimer's disease and other forms of dementia, which might predispose them to violent or aggressive behavior resulting in harm to others; and

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

[2] Section 19(3) of the *Act* provides:

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

II. MANDATE OF THE INQUEST AND STANDING

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

circumstances in the future. There is no authority under the *Act* for a judge to make recommendations to private individuals, businesses or corporations.

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

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

[6] The *Act* provides in section 28(1) that a person who "is substantially and directly interested in the inquest" may attend in person or by counsel and may examine or cross-examine the witnesses called. A Standing Hearing was held on January 11, 2013.

[7] Standing was granted to the Alexander family, the Winnipeg Regional Health Authority, Parkview Place Care Centre, the Winnipeg Police Service and the Government of Manitoba Department of Health. No further individuals or organizations made application for standing.

III. GLOSSARY OF TERMS

[8] Dementia:

A chronic, progressive neurological disease that affects memory, orientation, calculations, language, judgement and executive functions. There are a variety of diseases grouped with dementia such as Alzheimer's disease, vascular dementia and dementia with Lewy bodies to name some.

[9] Home Care:

The mandate of the home care program is to provide effective, reliable and responsible community health care services to support independent living, develop appropriate care options with clients and/or families and to facilitate admission into long term care facilities when living in the community is no longer possible.

[10] Long Term Care Access Centre:

The Long Term Care Access Centre is responsible for scheduling panel dates, ensuring clients have access to long term care services that are most appropriate to their needs and maintaining waiting lists for personal care homes/long term care programs.

[11] Panel:

Paneling is the approval process for eligibility for the Long Term Care Program including admission to the Personal Care Home Program. The Panel Review Board includes physicians and staff from the Long Term Care Access Centre and Home Care. Their role is to review the application information to ensure that the most appropriate care option has been determined.

[12] Paneling Process:

Once needs are no longer being managed at home, the Home Care Case Coordinator will review other options such as assisted living, supportive housing and companion care. If it is decided that moving to a Personal Care Home is the best option, steps will be taken to complete an application for long term care.

The Case Coordinator then completes an application form in consultation with the family and a heath care team.

If the application is approved by the Long Term Care Access Centre Panel Review Board:

- The individual's name is placed on the wait list for their preferred and/or alternate choice of Personal Care Home. Applications are

forwarded to the Personal Care Home by the Long Term Care Access Centre.

- A staff member from the Personal Care Home reviews the application and contacts the individual or family to ensure that the Personal Care Home can meet the individual's needs and to plan for admission.
- The Personal Care Home notifies the individual or family (and hospital if required) of the planned admission.

[13] PCH:

Personal Care Home – A Personal Care Home (PCH) provides personal care services to individuals who can no longer manage independently at home with family support and/or community services such as home care and where other assisted and supportive housing options are not suitable.

[14] P.I.E.C.E.S.:

Stands for Physical, Intellectual, Emotional, Capabilities, Environment, and Social. This is a program that stresses creative solutions to managing dementia behaviour. Health-care providers are taught to assess residents in each of these areas. They are, as a result, expected to be better equipped to manage the challenging behaviours of dementia patients – aggression, anxiety, calling out continually and wandering – without the use of medication, whenever possible.

[15] Respite Care:

The Respite Program arranges for dependent individuals, who require 24-hour care, to be admitted to a personal care home in order to provide a planned period of relief to families.

[16] WRC:

Winnipeg Remand Centre

[17] WRHA:

Winnipeg Regional Health Authority

[18] TAP:

Transition Advisory Panel – The purpose of this panel is to facilitate the placement of individuals with challenging behaviours in the most appropriate long term setting. The panel is a consultative group and members offer expertise related to the resources available to an individual.

IV. THE INQUEST

A. Summary of the Events of March 24, 2011

[19] On March 24, 2011 at approximately 7 p.m., Mr. Frank Alexander was found at Parkview Place, a PCH in Winnipeg, Manitoba, on the floor in the vicinity of the home's recreation centre. He was bleeding from his left ear and there was blood on the floor under his head. Staff called a medical emergency. Nursing staff attended to Mr. Alexander until Winnipeg Fire Paramedic Service personnel arrived. Mr. Alexander was then taken by ambulance to the Emergency Department, Health Sciences Centre, where he was diagnosed with a traumatic brain injury. A CT scan confirmed a left subdural hematoma with associated subarachnoid hemorrhage and a left occipital contusion, as well as degenerative changes. These findings were discussed with the family and, due to Mr. Alexander's poor prognosis, the family agreed to palliation. On March 28, 2011 Mr. Alexander was transferred to the Riverview Heath Centre where he died at 9:55 p.m.. The Medical Examiner's office was notified and an autopsy was authorized. The cause of death was blunt head trauma. The manner of death was homicide. Mr. Alexander had a past medical history of Alzheimer's disease.

[20] The Winnipeg Police Service (WPS) was notified of an alleged assault on Mr. Alexander. During the course of their investigation, it was determined that another resident with Alzheimer's disease, Joseph McLeod, age 70 years, had pushed Mr. Alexander, causing him to fall backwards and on his head. Mr. McLeod was taken to the Public Safety Building and charged with aggravated assault. This charge was later upgraded to manslaughter. Mr. McLeod was found unfit to stand trial. As a result, Mr. McLeod was transferred to a locked ward at the Selkirk Mental Health Centre. He has since passed.

B. Cause of Death

[21] On March 29, 2011, an autopsy was performed on Mr. Alexander by Dr. J. Younes at the St. Boniface General Hospital. The final autopsy report revealed Mr. Alexander's cause of death was the result of blunt head trauma.

V. WITNESSES CALLED AT THE INQUEST

[22] It is important to note that the evidence contained within this report is by no means a transcript of all of the evidence presented to the Court. It is, however, a summary of the relevant information communicated to the Court in the context of and within the parameters of this inquest.

A. Dr. Barry Campbell

[23] The inquest's first witness testified with a view to giving the Court an understanding of dementia, generally, and Alzheimer's disease, specifically.

[24] His qualifications were accepted by the Court by consent of all parties.

[25] The Court heard that there is no cure for dementia; only treatment. Dementia is a disease of late years. It robs a person of his or her abilities to perform complex activities; the ability to perform activities instrumental to daily living is lost. Dementia could ultimately rob a person of his or her ability to walk, talk, eat, etc.

[26] It is sometimes difficult to distinguish a person with Alzheimer's disease from a person without Alzheimer's disease. Other types of dementia are manifested in more obvious ways. However, high levels of cognitive ability are lost at the early stages of dementia.

[27] Alzheimer's disease is likely caused by a protein in the brain, which, when handled in a certain way by enzymes in the body, results in a neurotoxicity; the result being that the protein which a person has in the brain causes inflammation therein and kills neurons. This is something that occurs over many years. A person with the disease could sometimes go for many years without any symptoms.

[28] Alzheimer's disease is the most common form of dementia. It was not until the 1980s that medical professionals gained a better understanding of this form of dementia.

[29] An autopsy is ultimately the only way to determine with certainty if a person had Alzheimer's disease. Live diagnoses are 80 to 90 percent certain based on an analysis of history, medical tests, physical exams, cognitive exams and neuroimaging.

[30] Alzheimer's disease has various stages; seven of them. They range from getting the disease, to cognitive and functional impairment and, ultimately, to having no verbal ability and incontinence.

[31] Dr. Campbell testified that understanding the various stages of the disease could assist PCHs and the staff working therein to better deal with their residents.

[32] Agitation or a physical aggression is also often displayed. There could be signs of, amongst other things, verbal and physical aggression. As the disease progresses, the outwardly symptoms appear, increased motor activity could also occur (i.e.: wanderers).

[33] There is no treatment to control these symptoms, however medication is often used to modify the course of conduct.

[34] Dr. Campbell testified that 25% of persons in PCHs are prescribed anti-psychotic medication. He is of the view that medication is probably over used. In fact, legislation in the United States has been enacted so as to try to diminish its use.

[35] The first course of treatment for Alzheimer's disease and other forms of dementia is a behavioural approach towards persons affected; this method of treatment must be adapted. It is a very onerous approach. He is of the view that the overuse of anti-psychotic drugs may be explained by the very fact that the behavioural approach towards dealing with patients is much more onerous for care givers. Dr. Campbell confirmed that one cannot underestimate the importance of this behavioural approach to care giving.

[36] In this regard, and given the fact that the disease often progresses very rapidly, it is important to ensure that progress notes relating to a resident are properly kept within the facility.

[37] Dr. Campbell acknowledges that acute care hospitals (otherwise known as behavioural unit beds) are more ideal facilities for persons who exhibit aggressive behaviour. He understands that there are long waits to get into these facilities (given the fact that people stay there for a long period of time).

[38] When asked what makes "behavioural units" better than PCHs for persons who exhibit aggressive behaviour he testified that:

- They have ready access to geriatric psychiatrists;
- They have enhanced staffing;
- They have enhanced training of staff;
- They have an environment modified to provide safe care;
- They have a large open area where the residents reside; and
- They have a nursing station in the middle of the supervised area.

[39] Effectively, a behaviour unit makes it easier to assess environmental dangers; it is easier to assess risk and manage risk.

[40] Dr. Campbell testified that there is no definitive correlation between pre-existing behaviour and post-diagnosis behaviour in relation to Alzheimer's disease. Environment is more the cause of aggression than what the person brings as baggage.

[41] He acknowledges that if someone shows agitation and aggression while at a PCH they should be assessed by a specialized team. An application should perhaps be made to have the person moved to a specialized bed (i.e. behaviour unit); the individual in question should also benefit from "one-on-one" care, or consideration should be given to transfer a client to an emergency care unit.

[42] Dr. Campbell was informed of the following incidents involving Mr. McLeod while at Parkview Place:

- On October 29, 2010 Mr. McLeod was physically aggressive towards a health care aide.

- On October 30, 2010, Mr. McLeod became agitated and was hard to calm down.

- On November 2, 2010, Mr. McLeod was aggressive.

- On November 10, 2010, Mr. McLeod's roommate was accused of smoking and was chased outside of his room by him.

- On November 19, 2010, Mr. McLeod refused to take his medications.

- On December 15, 2010, Mr. Mc McLeod was aggressive.

- On December 23, 2010, Mr. McLeod was unpredictable.

- December 24, 2010, Mr. McLeod grabbed a person and as a result she banged her head.

- On December 28, 2010, Mr. McLeod's behaviour worsened.

- On December 31, 2010, a health care aide was subjected to Mr. McLeod's physical aggressiveness at which point he uttered a threat after grabbing her.

- On January 10, 2011, Mr. McLeod hit a health care aide.

- On January 23, 2011, Mr. McLeod was agitated during his bath.

- On January 31, 2011, Mr. McLeod was upset with a health care aide.

- On February 19, 2011, Mr. McLeod was aggressive and threatened a staff and resident. A "code white" was called within the facility.

- On February 20, 2011, an employee of the facility reported Mr. McLeod trying to hit him with a broom.

- On February 20, 2011, Mr. McLeod threatened a nurse with a water bottle, chased her, knocked over a table and hit a health care aide.

- On February 27, 2011, Mr. McLeod choked a health care aide, grabbed a nurse and hit her in the face.

[43] Presented with this degree of aggressiveness in relation to Mr. McLeod, the question was asked of Dr. Campbell as to whether it was predictable that his behaviour would continue and escalate. The response was, "It was hard to tell".

[44] Dr. Campbell, when asked about what opinions or recommendations he would have for the Court in the context of this inquest, stated that there was very little

awareness as to what is dementia amongst care givers and administrators alike in PCHs. The disease is very common and it will probably affect many of us. There is a definite need for heightened support for care givers. Care givers should be better informed and educated regarding the disease and the behavioural approach in dealing with persons affected.

[45] Dr. Campbell also opined that designs and approaches of and by certain facilities are not conducive to proper care (e.g. bright lights, large hallway settings, use of anti-psychotic drugs) and may contribute to resident agitation.

[46] Further, there needs to be a better ease of transfer (without lengthy waits) of a resident from a PCH into the acute care system once a problem is identified. It is clearly problematic when people end up in the wrong place for a long time. Individuals need the right care at the right time.

[47] Dr. Campbell testified that the optimum solution would be for all nurses, nurse's aides and health care aides to take P.I.E.C.E.S. training.

[48] There are a great number of complexities associated with caring for someone with dementia.

[49] Transition of care (i.e. shift changes in a PCH) is also important in the context of caring for a person with Alzheimer's disease; all care givers need to be familiar with the patient they are caring for. Noise, isolation, lack of appropriately engaging activities might trigger agitation and have a catastrophic reaction by the patient.

B. Faye Jashyn

[50] Faye Jashyn is the daughter of Joseph and Rose McLeod.

[51] Mr. and Mrs. McLeod are from Pine Creek, lived in Camperville and came to Winnipeg in 1964. Mr. McLeod worked for the CNR for 30 years as a welder. He retired in 1994 after which time he and Mrs. McLeod moved back to Camperville.

[52] Health issues forced the couple to return to Winnipeg in 2008.

[53] Changes in his behaviour were slow; a normally calm man eventually would get angry with people close to him.

[54] In 2009, matters devolved to the point that he chased a person from the Transcona Access Centre from his home. Mrs. McLeod was now taking care of all of the day to day responsibilities of the household, including the finances. This, apparently, caused him grave concern.

[55] On September 7, 2010, Mr. McLeod was at his home, in Winnipeg, with Mrs. McLeod; he did not recognize her and wanted her to leave out of concern that his "wife" would soon be home and he did not want her to see a strange woman in the house. In an attempt to convince him who she was, Mrs. McLeod picked up a framed wedding photograph and showed it to her husband. Mr. McLeod pushed her out of the door; Mrs.

McLeod fell and the frame she was still holding broke and cut her chest; she was bleeding profusely. Police were called.

[56] Ms Jashyn testified that by the time she attended her parents' house both the police and the ambulance were already on scene. She recalls her father talking calmly to the police, not at all realizing what he had just done.

[57] Mrs. McLeod required numerous stitches and was hospitalized overnight.

[58] Mr. McLeod was taken to the Concordia Hospital, was assessed and was cleared medically. He had no idea what was happening.

[59] Ms Jashyn confirmed that the police took Mr. McLeod to the Concordia Hospital with a view to being assessed by a psychiatrist. She is not sure what the results of the assessment were; the family was told nothing.

[60] The police indicated that Mr. McLeod could either go home or go to the WRC. Ms Jashyn was scared to take him home given his conduct; she did not know what else to do. She was concerned for her children (ages 13 and 16 at the time) and did not want to have her father at her home in his current condition. This had been the first time that Mr. McLeod had ever been involved with the police.

[61] Given Ms Jashyn's decision not to take her father into her home, Mr. McLeod was taken to the WRC, processed and charged with a domestic violence assault. He had no other place to go.

[62] Ms Jashyn testified that she tried calling anyone who she thought might help her to determine what to do next. She spoke to a Dr. Duplessis. Dr. Duplessis told her that if she took him in at her home and could not handle him that she should take him to the hospital and "abandon" him.

[63] Ms Jashyn emailed her member of the Legislative Assembly, namely Daryl Reid, regarding the panelling process. He wrote back and advised her "not to worry" and that the panelling process would take some time. Mr. Reid never offered any specific help. He simply told her to wait and to let the process take its course. She also spoke to Bill Blaikie, who knew her father; Mr. Blaikie basically advised her as Mr. Reid had. She then called the Alzheimer's Society of Manitoba and sought advice.

[64] Ms Jashyn testified that a concerned friend from Camperville contacted Jon Gerrard (leader of the Manitoba Liberal Party as he then was) and asked if he could be of some assistance. This took place on September 17, 2010. Jon Gerrard eventually communicated with Ms Jashyn and advised her that he would help to get Mr. McLeod out of the WRC and into a PCH. He had suggested a press conference to get the issue out into the open with a view to putting pressure on people to get him into a PCH. The objective was public awareness.

[65] The press conference took place on September 20, 2010. Following the press conference, a bail hearing took place at which time a forensic assessment was ordered by the Court. A few days following the assessment being ordered, it was confirmed that

Mr. McLeod had, in fact, a PCH placement. On the morning of Mr. McLeod's release, Ms Jashyn was informed that her father would be going to Parkview Place. Ms Jashyn testified that neither she nor her mother had any input regarding this placement. This was October 8, 2010.

[66] Ms Jashyn stated that her father was at the WRC for almost 30 days. While there she never got a chance to see him or call him. She did indicate that her aunt and a priest saw him while in custody.

[67] When Mr. McLeod was finally released from the WRC, Ms Jashyn picked him up and took him to Parkview Place. Her father was emotional on the day of his release but he did recognize his wife. That said, he was confused and did not know the difference between Parkview Place and his own residence.

[68] Ms Jashyn clearly recalls the day of his arrival at Parkview Place; they were greeted and they were taken up to Mr. McLeod's designated room, after which they were given a tour of the facility. There were a lot of people around. Ms Jashyn confirmed that Parkview Place was aware that he had come from the WRC but there were no discussions regarding the events which led him to be incarcerated.

[69] A care plan was put into place a few days later. The care plan included, amongst other things, details relating to activities and medications.

[70] When Mr. McLeod was first brought to Parkview Place, he was in a room with another gentleman. Soon thereafter, it became evident that the roommate was making her father angry. Mr. McLeod had locked his roommate out of the room after pushing him out. Following this incident, Parkview Place moved Mr. McLeod to a single room for the balance of his stay.

[71] Ms Jashyn testified that from October 2010 to the spring of 2011 he had "good days and bad days" at Parkview Place. She would sometimes get calls from Parkview Place about her father's altercations with others. It was not often that she would receive these calls but she does remember approximately six of them which were always prefaced by "it's nothing serious". She also recalls being informed by Parkview Place that they would be adjusting his medications as he was having some trouble sleeping.

[72] Following his move to a single room, Ms Jashyn had a "report card meeting" with the care givers at Parkview Place. This meeting addressed, amongst other things, feeding, behaviour and other activities. Those in attendance included the dietician, a social worker and a physiotherapist. Ms Jashyn was the only person in attendance at that meeting from her own family.

[73] Ms Jashyn testified that Parkview Place always confirmed that they would take care of her father and that she was never advised that they could not handle him. She was always of the view that the level of care would address his circumstances.

[74] When she visited her father at Parkview Place the nurses or the aides would sometimes share with her details of the incidents in which he was involved. She recalls

approximately one half dozen incidents. It was never suggested by Parkview Place, however, that he should be moved to another facility.

[75] Ms Jashyn confirms that in February of 2011 there were two incidents which required the attendance of the Winnipeg Police Service. She advised that she was never informed of these incidents until after March 24, 2011. On that day, she was told that the February, 2011 incidents involved pushing, shoving and grabbing others within the facility. Her father was a strong man.

[76] Ms Jashyn testified that she found out about the incident involving Mr. Alexander on March 25, 2011. She was called by Parkview Place and told that the police were on their way regarding an assault which had allegedly taken place. She was not informed of Mr. Alexander's condition. Since Ms Jashyn was leaving the City, she asked her brother to attend to the Public Safety Building to meet with her father. She stated that she had called some police officers that she knew to get some information about what had transpired. The police informed her that her father had assaulted a patient, that he was being questioned and that he was being held at the Public Safety Building. Ms Jashyn called a lawyer, Evan Roitenberg, since she was told that this was a serious case. In the evening of March 26, 2011 she was informed, through the media, that the person that her father had apparently assaulted was in critical condition. She again, through the media, found out that Mr. Alexander had ultimately passed away as a result of the injuries which he had suffered.

[77] Mr. McLeod was taken from the Public Safety Building to the Health Science Centre "PX3" with a view to getting a better assessment. He was not erratic, he was very calm. She met with Dr. Yaren who explained how they would be dealing with her father at PX3. He also told her that the family would be involved in the process regarding the assessment. She felt that this was the first time anything was explained to her and to the family members about the process throughout her travels through the system.

C. Jon Gerrard

[78] Court heard from Jon Gerrard, Member of the Legislative Assembly and, at all times material, Leader of the Manitoba Liberal Party.

[79] Mr. Gerrard testified that he knew both Mr. and Mrs. McLeod and had met them while they were still residents in Camperville, Manitoba. After meeting the couple in Camperville, Mrs. McLeod (in 2007) told him that Mr. McLeod was becoming quite demented and that they had no choice but to move from Camperville as there was no care facility in the area to address his medical needs. He remembers Mr. McLeod as being a calm and nice man.

[80] Mr. Gerrard stated that in the fall of 2010, he received a call from a resident of Camperville (who had communicated with his assistant) to advise of Mr. McLeod's situation, namely the fact that he was at WRC. He was not aware of Mr. McLeod's predicament prior to receiving this call from the Camperville resident.

[81] Mr. Gerrard called Mrs. McLeod; she gave him the details of the assault and the follow-up consequences.

[82] Mr. Gerrard informed that he was aware that Mr. McLeod had Alzheimer's disease.

[83] Mr. Gerrard communicated with Faye Jashyn (whom he had known since October 2010) who filled him in on further details. He testified that, following the receipt of this information, he sat down with his staff and talked about what could be done by them given the fact that Mr. McLeod was at the WRC. As a result, a decision was made to take this issue to the media on October 6, 2010.

[84] Mr. Gerrard testified that Mrs. McLeod was simply asking him to do what he could to get Mr. McLeod into a better environment.

[85] A press conference was organized on October 6, 2010 and this immediately garnered public attention. Both Mrs. McLeod and Ms Jashyn were present. Mr. Gerrard testified that the WRHA initially confirmed that it would take some time for Mr. McLeod to get processed and into the system. That said, between October 6 and October 8, 2010, Mr. McLeod was assessed, deemed by the WRHA to be eligible and he was admitted to Parkview Place.

[86] Mr. Gerrard also testified that on or about March 25, 2011 he had learned that Mr. Alexander was hurt by Mr. McLeod. A further press conference was organized for March 26, 2011 with the view to expressing regret and concern regarding the entire situation.

[87] He indicated that his role throughout was simply to bring the situation regarding Mr. McLeod's incarceration at the WRC to the public's attention. He testified that he took no other steps on behalf of the McLeod family to fast track Mr. McLeod's assessment and/or placement.

[88] Mr. Gerrard acknowledged that the paneling process is put into place by the Department of Health to ensure fairness and to ensure that no one receives preferential treatment. However, Mr. Gerrard was of the view that Mr. McLeod should have been looked after by the Department of Health instead of the Department of Justice or Corrections. He was aware that there were limited beds for high risk individuals in 2010 and that there was normally a period of time between an application and panelling

[89] Mr. Gerrard was left with the impression that the only option available to Mr. McLeod at the time of the original assault on Mrs. McLeod was the WRC. He did not investigate steps which had previously been taken by the Department of Health. He went directly the political route; two days later, Mr. McLeod was released from the WRC and admitted to Parkview Place.

D. Donald Michael Solar

[90] Mr. Solar is the Executive Director of Parkview Place and was its Executive Director at all times material. He has acted in this capacity for the last fifteen years.

[91] Parkview Place opened in 1964. Its original purpose was not a PCH but rather a facility offering “assisted living”. It has thirteen stories of which twelve floors are for residents. It has the capability of accepting two hundred and seventy seven residents.

[92] Mr. Solar described Parkview Place as being the second largest PCH in Manitoba. It was originally built in the style of an apartment complex. It has a mix of private and semi-private suites.

[93] Demographics at Parkview Place are quite unique in terms of PCHs. The average age of the residents is 76; the WRHA average is approximately 84 years of age. The population at Parkview Place is thirty percent male (the average male population in the WRHA is twenty percent). There are a number of residents who have chronic illnesses who are of younger age. Over forty percent of the residents are under the supervision of the office of the Public Trustee. A number of residents are supported by income assistance. Thirty percent of the residents are under the age of seventy five.

[94] There are no specialized or behavioural units at Parkview Place.

[95] Mr. Solar testified that if there is a vacant bed in the facility and an application is made for admission, Parkview Place makes sure that the person who makes the application and who is admitted is suited for the facility generally, and for the floor on which this person is placed, specifically. There are no locked wards. He did however indicate that the exit doors on each floor (the stairs) at the end of the hallway are keypad locked.

[96] The main floor in the building has a recreation room and a dining room. He described the main floor lounge as being quite active throughout the day except for meal times. There are structured activities, there is a large screen T.V., a small library, and a small smoking lounge.

[97] Parkview Place is owned by Revera Inc., which is based out of Mississauga, Ontario. Revera Inc. has a number of policies and procedures which have to meet with regulated standards. This is done by corporate officers that receive feedback from each jurisdiction in which it operates.

[98] Mr. Solar testified that staffing at Parkview Place is made up of the following departments: food services, environmental services, recreational staff, nursing department, occupational therapy and rehabilitation aides. The nursing department consists of thirteen to fourteen nurses for the twelve residential floors (registered nurses or LPNs). Twenty-four health care aides (two per floor) also work the day shift. The day shift is from 7:15 a.m. to 3:15 P.M.

[99] The nursing staff is made up of fifty percent registered nurses and fifty percent LPNs. There are typically two supervisors (resident care managers) who work the day shift (on some days there are three to four supervisors on duty). The resident care managers are all registered nurses.

[100] Mr. Solar described that there are a number of health care aides who work at the facility. Health care aides have the greatest amount of “hands on care” with the

residents of the PCH. The duties involved include assisting with dressing, personal care, bathing, feeding, etc. Nurses, in general, have more of an oversight role on each of the floors.

[101] The evening shift, which is from 3:15 P.M. to 11:15 p.m., has a different staffing ratio. There are nine to ten nurses for the twelve residential floors together with the same number of health care aides as during the day shift. During the evening shift there are 1.6 resident care managers on duty.

[102] There is a nursing station on each floor situated in the core area of the floor adjacent to the two elevators which make their way throughout the building. The nursing stations are recessed and they do not have any sightlines to the rooms.

[103] During the night shift, which is from 11:15 P.M. to 7:15 a.m., there is one resident care manager, four nurses for twelve floors and sixteen to eighteen health care aides working throughout the building.

[104] The minimum staffing requirements for Parkview Place are 3.6 hours of care per resident. Day staffing is based on the number of residents and consists of fifteen percent nurses, fifteen percent LPNs and seventy percent health care aides.

[105] Mr. Solar described Parkview Place as often being an interim place for residents to stay while they await placement into a PCH of choice or while waiting to be panelled.

[106] There are four family physicians who provide medical support (these are physicians who have their own practices). The doctors set a routine visiting pattern depending on their respective case loads. They are also “on call” for the residents.

[107] In terms of psychiatry, Parkview Place had a consultant psychiatrist available to them until October of 2012. These services have since been withdrawn.

[108] With respect to the P.I.E.C.E.S. training, Mr. Solar completed his own training approximately five to six years ago. He testified that the full time nurses attend for P.I.E.C.E.S. training (four to five day sessions) and the health care aides go to a one day training session. He did confirm that P.I.E.C.E.S. training is not a requirement for all of the staff working within the facility. It is a one-time educational session with no refreshers. He testified that P.I.E.C.E.S. is more “nursing” based rather than “personal care” based. Not all of the health care aides at Parkview Place currently have P.I.E.C.E.S. training.

[109] Mr. Solar testified that a respite application is made when an individual’s care needs cannot be met in the community and the placement is intended to be temporary until alternative arrangements are made (i.e. paneled or otherwise).

[110] Mr. Solar went into a fair bit of detail regarding how applications are reviewed by Parkview Place before determining admissibility. The administrative team meets every morning (morning report) from Monday to Friday during which time applications for review are presented and considered by the team. He normally sits in on the portion of

the meeting dealing with the review of the applications. So too are the social worker, department managers and a representative from nursing.

[111] He acknowledges that never had he before received an application on behalf of an individual for respite who was in jail. Usually it is from the community or from a hospital. Mr, McLeod's situation was a first for him.

[112] During a typical week there are seven to ten applications which are considered by Parkview Place.

[113] He acknowledges that some applications for respite are urgent depending on the nature of the circumstances. It is not abnormal for urgent applications to have a quick turnaround. Normal applications take four to five days depending the speed at which information is received.

[114] Admissions can be declined by Parkview Place and are refused if an individual's care needs are greater than what the facility can handle.

[115] Mr. Solar went into a fair degree of detail regarding the reporting protocols at Parkview Place in terms of incidents occurring at the facility. He spoke of the shift communication log which is a handwritten log completed by the resident care manager or the charge nurse. Further, and as indicated earlier, there are morning report meetings which serve as a communication tool for the administrative team to share "whatever happened in the last 24 hours which was noteworthy". Mr. Solar, however, is not always present at these morning meetings. The types of matters which are reported at the morning meetings include abuse or injuries by or to residents or staff.

[116] The shift log contains information which could range from how a resident slept or whether an assault occurred. There is also a requirement to complete occurrence reports in the case of falls, medication administration errors, abuse by staff or abuse by one resident to another resident. He confirmed that the WRHA obligates Parkview Place to complete occurrence reports in these cases. It is a requirement for the nurse to complete and ultimately give the occurrence report to a resident care manager. If an employee is injured, Parkview Place is required to generate what was referred to as an employee injury report.

[117] When questioned about the threshold of the type of occurrence that needs to be reported, Mr. Solar testified that any occurrence needs to be reported. When defining "occurrence" he gave examples of falls, physical interaction, medication administration errors or physical contact between residents or between a resident and a staff member.

[118] All of the foregoing protocols are communicated to staff members as part of the orientation program provided by Parkview Place at the commencement of employment.

[119] Mr. Solar was asked how he would assess the quality of the reporting globally in his facility. He responded that there are still times where more information is needed after review of the shift communication report. This would be handled by either the resident care manager or the director of care. He indicated that it is probably not 100%,

as reporting is based on how one assesses or evaluates the seriousness of a particular incident.

[120] In the fall of 2010, Mr. Solar was made aware, through media reports, that Mr. McLeod was in the WRC. The first contact he received regarding Mr. McLeod was from the manager of Long Term Access at the time (Joanne Dinicola). She called him on either October 5th or 6th, 2010 to inquire about the availability of bed space. Mr. Solar responded that he would look into availability and that he would need further information before ultimately determining if he could accommodate the request. Later that same morning, Réal Cloutier (Vice-President of PCHs at the time) called him to discuss the possibility of Mr. McLeod being admitted to Parkview Place. This type of call from Mr. Cloutier was not common but did happen from time to time on a yearly basis. Mr. Solar testified that if he was to consider admitting Mr. McLeod at Parkview Place he needed his social worker to attend and meet with him for a pre-admission assessment.

[121] Jeff Roos (social worker at Parkview Place) attended for a community assessment at the Transcona Access Centre. Following this assessment, Mr. Roos returned to Parkview Place, met with Mr. Solar, the director of care and other social workers and communicated that, in his view, Mr. McLeod's situation was not that dissimilar to others already in the facility and that he should be admitted. This meeting took place on October 7, 2010. Mr. McLeod was admitted to Parkview Place on October 8, 2010. Mr. Roos' global impression of Mr. McLeod was that nothing was unusual or extraordinary in the context of admissibility. In fact, quite often, applications are received by PCHs where there is aggression to a spouse or a care giver. It is often a triggering event for respite or paneling.

[122] Mr. Solar testified that he felt no pressure to say "no" to Réal Cloutier regarding the request for urgent respite. If Parkview Place could not have met Mr. McLeod's needs he would not have been admitted.

[123] Mr. Solar confirmed that he only found out about the circumstances of Mr. McLeod's assault on Mrs. McLeod after the admission to Parkview Place.

[124] Mr. Solar first saw Mr. McLeod personally on October 8, 2010, upon his admission to Parkview Place. He recalled having a certain concern regarding the media attention as there were camera people on the front street as Mr. McLeod was being admitted.

[125] Mr. McLeod was first assigned to sharing a room with another individual on the tenth floor. One month later, a private room was provided for Mr. McLeod on the ninth floor of Parkview Place. He recalls being apprised of an incident which prompted the move from the tenth floor to the ninth floor at one of the morning meetings. This was a factor in the decision to move Mr. McLeod to a private room. Mr. McLeod needed a quieter space as he did not deal well with a roommate.

[126] Mr. Solar confirmed that he was informed of a number of incidents in 2010 and early 2011 regarding Mr. McLeod. He acknowledged that no occurrence reports were prepared in relation to some if not most of these incidents. He acknowledged that had

occurrence reports been prepared in relation to all of the incidents he may have taken a closer look as to whether Parkview Place was the best environment for Mr. McLeod.

[127] Mr. Solar testified that Mr. Alexander was introduced to Parkview Place in January of 2011. His application came through as "community urgent". He was a risk for "wandering" but Parkview Place concluded that it could meet whatever needs he required. His admission to Parkview Place was on January 20, 2011.

March 24, 2011:

[128] Mr. Solar testified that he was not on site at the time of the incident. However, he was present on the following day when the police attended. He gave the police all of the information that he had available. He spoke to witnesses and with the recreational facilitator.

[129] Mr. Solar confirmed that, as a result of the incident involving Mr. McLeod and Mr. Alexander, there was some tightening up of the incident reporting protocol at Parkview Place. He acknowledged that since March of 2011, it was accentuated to the staff that occurrence reports were paramount to ensuring that this type of event or incident be prevented in the future.

[130] Mr. Solar advised that there is no dedicated floor at Parkview Place for "problem" residents. There is no separate area, ward or unit within the facility to isolate residents who exhibit aggressive behaviour. A resident can, in theory, be free to wander throughout the facility of his or her own accord.

[131] With respect to the "lounge area", no staff member is specifically assigned to that space other than the recreational staff and the reception staff.

[132] Mr. Solar agreed to the following:

1. That there was, with respect to certain incidents involving Mr. McLeod, a lack of documentation outlining what had transpired;
2. That, in retrospect, there was a lack of action when incidents of aggression occurred;
3. That there was a lack of action when Mr. McLeod refused to take medication;
4. That there was a lack of a secure area to address Mr. McLeod's particular needs and aggressive behaviour; and
5. That there was a lack of supervision on the main floor.

E. David Thorarinson

[133] Mr. Thorarinson has been living at Parkview Place for approximately six years. He is 63 years of age and clearly recalls the events of March 24, 2011.

[134] At approximately 7:00 p.m. on the evening in question, Mr. Thorarinson was in the recreation room on the main floor of Parkview Place and was searching for something to do. A Bingo game was being called. When he arrived on the main floor he saw both Mr. McLeod and Mr. Alexander. Mr. McLeod was seated on the couch and Mr.

Alexander was making his way over to talk to him near the entrance to the recreation room.

[135] Mr. Thorarinson testified that he was approximately ten meters away from where Mr. McLeod and Mr. Alexander were interacting. He did not recall seeing anyone else in the recreation room other than persons playing Bingo. One staff member was present, namely the person responsible for calling the Bingo game; fifteen to twenty people were partaking.

[136] Mr. Alexander wanted to talk to Mr. McLeod and Mr. McLeod wanted nothing to do with it. Mr. McLeod seemed to be bothered by the fact that Mr. Alexander was trying to engage him in conversation. Mr. McLeod got up from the couch and pushed Mr. Alexander. Mr. Alexander took a couple of steps back, fell down and hit his head. The push was to Mr. Alexander's chest. There were no other physical acts of aggression; just the one push. Mr. Thorarinson recalls that prior to the push, Mr. Alexander and Mr. McLeod were not speaking loudly to each other. Following the push, Mr. McLeod returned to his sofa and sat down.

[137] The staff person who was responsible for the Bingo game called the nurses for help and an ambulance was ultimately summoned. Following the incident, Mr. Thorarinson talked to Mr. McLeod and asked him if he realized what he had done. Mr. McLeod simply responded that Mr. Alexander was always following him.

[138] Mr. Thorarinson stated that he really did not know either Mr. McLeod or Mr. Alexander very well as they were both relatively new to Parkview Place. He did, however, know that Mr. Alexander had a tendency to walk around and "bother" people; but he never did anything physical to anyone.

[139] The incident took place near the lobby entrance. The person who would have been seated at the front desk on the main floor would not have been in a position to see the incident as it is approximately nine meters away and out of sight.

[140] Mr. Thorarinson recalled that Mr. McLeod had stated to Mr. Alexander, immediately prior to the incident, that "If you don't think I can push you, you're wrong".

F. Aurelia Ho

[141] Aurelia Ho is a retired nurse who was, on March 24, 2011, a floor nurse working at Parkview Place. On the day in question, she was working the evening shift and recalls there being no resident care coordinator on duty. Ms Ho was, therefore, in charge. She testified that if there is no resident care coordinator on duty, the registered nurses take turns, in an acting capacity.

[142] On March 24, 2011 she heard a "code blue" over the intercom. Mr. Alexander was on the main floor by the entrance to the activities room and had fallen. A number of nurses responded to the called code.

[143] Ms Ho indicated that there were usually two activity workers working on the main floor but she only recalls there being one on duty that specific evening.

[144] Mr. Alexander was bleeding from one ear. She asked one of the orderlies to get an ice pack and some towels. She directed one of the nurses to call 911. Another nurse was asked to get an apparatus for vitals and some paperwork from the sixth floor to give to the ambulance attendees before Mr. Alexander's transit to the hospital. Other health care aides and nurses were helping redirect the other residents who had been in the recreational area. Police were ultimately called by the ambulance attendees.

[145] Ms Ho had not yet been informed that Mr. Alexander was pushed. She asked one of the orderlies to clean the floor as she was concerned that one of the residents would slip on the blood.

[146] Mr. Alexander was restless but alert and said that he did not want to go to the hospital. Mr. McLeod sat quietly in a black leather chair. She asked one of the floor nurses to call the doctor and to communicate with the Alexander family. Once the police arrived she went to her designated floor and continued with her regular duties.

[147] She recalls Mr. McLeod stayed downstairs until late; he returned to his room at approximately 10:00 p.m., took his pills and went to bed.

[148] Ms Ho testified that she was the senior person in the building on that day. She informed the director of nursing and Mr. Solar of the details of what had transpired. She wrote the incident down in a "24 hour" report.

[149] Ms Ho confirmed that there has been extra staff in the lounge area at Parkview Place since the Alexander/McLeod incident. Prior to March 24, 2011, the receptionist was basically the only person on the main floor, save and except for the nurses who were going up and down to and from their respective floors.

[150] Prior to the incident in question, Ms Ho really had no involvement with Mr. Alexander. She does, however, recall one "code white" or stat call on the ninth floor involving Mr. McLeod. She attended and saw that Mr. McLeod was being aggressive with other residents along the hallway. He was running after residents. During this incident, a health care aide tried to redirect him to his room; Mr. McLeod was fighting. The doctor was called and he prescribed medication. They had a hard time administering his medication. She also had a vague recollection of other incidents involving Mr. McLeod but could not recall them with any great detail.

G. Jeffrey Roos

[151] In October of 2010, Mr. Roos was employed at Parkview Place as a social worker. His responsibilities included, amongst others, admissions, planning and support for the families. He is now employed by the Long Term Care Access Centre.

[152] At all times material to the events in question and while at Parkview Place, Mr. Roos was responsible for receiving applications and presenting them to the Parkview Place management team, which team ultimately determined whether an applicant could be admitted (or not) to the facility.

[153] Mr. Roos testified that the Parkview Place management team was comprised of the following individuals:

- executive director;
- dietician;
- resident care manager;
- food services supervisor;
- both social workers;
- environmental services supervision; and
- the recreation supervisor.

[154] When an application came to Parkview Place from the Long Term Care Access Centre, it was analyzed by this team with a view to determining if the individual in question was an appropriate fit for the facility. The criteria varied slightly from time to time but included a review of the following questions:

- Would the potential client fit well with a particular room-mate?

- Would the potential client fit well in Parkview Place's general environment?

- Could Parkview Place manage the potential client?

[155] Mr. Roos confirmed that Parkview Place has no special unit within the facility for individuals with behavioural problems.

[156] Parkview Place was always open to accepting a varied type of clientele.

[157] A pre-admission assessment by a representative of the facility was sometimes necessary to determine if the potential client could be properly managed. He stated that ". . .sometimes taking a look at a (potential client) with your own eyes was necessary". It often depended on the state of the paperwork as to whether an "in person" assessment was required. In this regard Mr. Roos testified that he would have preferred to see everybody and he had made this known to management. However, for the most part, if there were questions surrounding the application, Parkview Place would ensure a personal visit.

[158] Mr. McLeod's "urgent respite" application was discussed as a team. Mr. Roos recalls finding out about Mr. McLeod's situation through the media. Management at Parkview Place thought that his application may come to them. It did. He recalls the application being forwarded to Parkview Place from the Long Term Care Access Centre and it being reviewed by the team. A decision was made to see Mr. McLeod and to conduct a pre-admission assessment. In this regard, Mr. Roos attended the Transcona Access Centre with Greg Lussier (the assigned community case coordinator) and a psychiatrist. Mr. McLeod had been transported to the Transcona Access Centre from the WRC, in shackles, an orange jump suit and accompanied by two "guards".

[159] Mr. Roos testified that he had been apprised of the reason Mr. McLeod was in remand custody. He acknowledged that this information was certainly relevant for the purposes of the pre-admission assessment. Behavioural issues of the sort could

sometimes result in a rejection unless other resources can be put into place to manage same. He was also informed that there were no behavioural problems by Mr. McLeod while at WRC.

[160] This was the only time he had ever dealt with a person in custody in the context of an assessment. However, following a review of the application, meeting with Mr. McLeod and having a discussion with the family, Mr. Roos was quite confident that he could be managed at Parkview Place. In his view, Mr. McLeod looked like the "average client". In fact, he felt that Mr. McLeod's care needs (i.e. activities of daily living) would be relatively light (i.e. dressing, eating, toiletry, etc.). He did admit that making such a decision based on a "one hour" visit (at the Transcona Access Centre) was difficult.

[161] Mr. McLeod was accepted by Parkview Place and admitted to the facility. It was a very quick turnaround.

[162] Following his admission, Mr. Roos vaguely recalled being apprised, from time to time (mostly at morning management meetings), of behavioural issues with Mr. McLeod. Responsive action would be discussed; however Mr. Roos was rarely called upon to be part of that "action".

[163] Mr. Roos testified that, although he did not yet have the application material with him (from the Long Term Care Access Centre) at the time of his pre-admission visit with Mr. McLeod at the Transcona Access Centre, there was nothing that was contained therein (upon follow-up review) that would have changed his mind regarding Mr. McLeod's admissibility at Parkview Place. Everyone on the management team was aware of the September, 2010 assault on Mrs. McLeod.

[164] Mr. Roos was questioned about the potential benefits of Parkview Place applying for one-on-one care for Mr. McLeod to address concerns raised by his aggressive behaviour while at the facility. Mr. Roos testified that the nursing department at Parkview Place is typically responsible for such applications. However, Mr. Roos stated that it is highly unlikely that such a resource would have been beneficial as Mr. McLeod would probably not have reacted well to someone "following him" all day long.

[165] Mr. Roos reminded the court, in concluding his evidence, that the first course of action in a PCH is not to get rid of someone who is exhibiting responsive or aggressive behaviour. It is not simple to get someone out of a PCH. Action could include:

- medical assessment;
- P.I.E.C.E.S. assessment; and
- review of medication.

H. Heidi Williams

[166] Heidi Williams is a licensed practical nurse who worked at Parkview Place since July of 1985. She is currently on sick leave and has been for approximately one year.

[167] She testified that, ideally, there should be one nurse working per floor. The reality was often that a nurse had to work two floors. Typically, they were assigned to more than one floor during any given shift.

[168] Over the last four or five years of her time at Parkview Place, Ms Williams was working part time nights. During the night shift she would often be responsible for three or more floors. She described that Parkview Place was often short staffed.

[169] Ms Williams testified that when she began her employment at Parkview Place, training was a requirement and staff would often be asked what else they needed or wanted in terms of additional education. Over time, opportunities for training changed as two educators were lost by virtue of budget constraints. Education opportunities were hardly existent once this happened.

[170] With respect to "P.I.E.C.E.S." training, staff were simply given a brochure and very few people were able to attend. There were even less opportunities for night staff to go for P.I.E.C.E.S. training.

[171] Ms Williams testified that she often paid for some of her own education opportunities (i.e.: Non-Violent Crisis Intervention). In response to enquiries about the possibility of further education opportunities, management often suggested that she should simply "ask her co-workers". Generally, she described the training remaining opportunities at Parkview Place to be mostly only available to full time staff.

[172] Ms Williams confirmed that she never received the P.I.E.C.E.S. training.

[173] She described the resident population at Parkview Place as being mid-life to older. In her view, it seemed that Parkview Place took anybody in to fill beds that they had open.

[174] Ms Williams went into a fair bit of detail regarding the procedures adopted by Parkview Place to report incidents. She indicated that there was a "report book" on every floor. There was a requirement to report incidents to nurses who would then in turn report to nurse managers. The standard procedure for each incident was to make notes of the incident in the integrated progress notes (IPN), detail them in a log book located on each floor; the nursing manager on the main floor desk would thus be informed.

[175] Occurrence reports were prepared only if asked for by nurse managers. It did not necessarily depend on the seriousness of an incident. Further, report forms were not always easily accessible. She testified that occurrence reports were mandatory for falls, but occurrences were not to be mentioned in the progress notes. These occurrence reports were also necessary for medication administration errors and aggressions by patients. She indicated that she would fill out the form only if she was provided with same.

[176] With respect to Mr. McLeod, she recalls that he once refused his medication and the nurse said that when the family came in, they could administer same. That information was put into the IPN.

[177] She testified that not every nurse reported everything of significance.

[178] Ms Williams advised that she was never given any information regarding Mr. McLeod's background. Only shift to shift information was provided to her. She indicated, however, with twenty three patients to look after on any given shift, there was no time to read up on each patient.

[179] She further recalled one incident with Mr. McLeod where she had to attend and take him out of the nurse manager's office. He was being aggressive towards the nurse who was hiding behind fire doors to protect herself from him. A "code white" was called and the police were summoned. Mr. McLeod had a "look of rage" in his eyes. During the course of this incident, one nurse told Ms Williams not to call the police.

[180] A memo had been prepared and signed by Donald Solar, the contents of which stipulated that if a certain resident "and everyone knew that it related to Mr. McLeod" acted up, that a "code white" was to be called and that the police were not to be summoned. It was posted on the 9th floor (Mr. McLeod's floor). She showed the memo to the police when they attended. The police told her that they were not going to be taking Mr. McLeod into custody since he had Alzheimer's disease. The police left 10 minutes after their arrival.

[181] Ms Williams recounted the details of a second incident involving Mr. McLeod. This was on or about February 22, 2011. She informed that she was working nights and that she was assigned to the 9th floor. She was at her desk doing paperwork shortly after midnight when she witnessed Mr. McLeod starting to strangle a health care aide. Ms Williams received a blow to the right side of the head during the mêlée which ensued. She had tried to intervene.

[182] Mr. McLeod had refused his medication earlier that evening; she was not apprised of this until after the fact. Had she known that he was refusing his medication, alternative measures could have been taken. She recalls Mr. McLeod having his hands firmly around the health care aide's neck. Once Ms Williams stood up from the desk, Mr. McLeod let go of the health care aide's neck and he grabbed Ms Williams' arm and said "let's go to work". Mr. McLeod brought Ms Williams into the elevator and she pressed the first floor button. Her instinct was to go where people were present. At that point and while in the elevator his fist went through her hand (which was up as a protective response) and into her face and onto the right side of her nose and right cheek.

[183] After this elevator incident, Ms Williams took three or four days off, after which she came back to work. She filed a Workers Compensation Board claim "following the death of Mr. Alexander". She testified that she suffered a concussion and her nose was broken. She went off work in May 2011. Her Workers Compensation Board claim was ultimately dismissed as was the appeal.

[184] Staff members were refusing to work with Mr. McLeod.

[185] On another occasion a "code white" was called and Ms Williams asked that Mr. McLeod's doctor be called. The police were not called on this occasion as the memo was still posted directing the staff "not to call the police". The incident was entered into

the log notes, no accident report was required as Ms Williams was told this by “higher ups”.

[186] When asked questions about her first incident involving Mr. McLeod, she testified that it was the floor nurse’s responsibility to file an occurrence report. In as much as this was not her floor on that night and that she was simply asked to go get Mr. McLeod, she did not complete an occurrence report.

[187] Regarding both of her incidents with Mc McLeod, Ms Williams testified that no one ever contacted her from management to enquire about what had transpired.

[188] Ms Williams testified that she had not heard of P.I.E.C.E.S. before the death of Mr. Alexander; only after his passing.

[189] Ms Williams reported the February 22, 2011 incident to the police on July 16, 2011. She decided to go to the police because of a lack of action regarding her situation by both Parkview Place and the Workers Compensation Board.

[190] Her concern, generally, is that the focus at Parkview Place is on residents being injured versus staff being injured. She is of the view that no one at Parkview Place cares about the staff.

I. Joanne Dinicola

[191] Ms. Dinicola is currently the Manager of Personal Care Home Initiatives with the WRHA. In 2010 and 2011 she was the Transition Manager – Long term Care Program.

[192] Her evidence was helpful as she guided the Court through the various types of circumstances and scenarios which bring people in need of long term care into the system.

[193] Ms. Dinicola described three different types of care requests:

1. Community Active Request;
2. Community Urgent Request; and
3. Urgent Respite Request.

[194] The most common of the three is the Community Active Request. A formal application is prepared for panelling. If accepted at “panel”, the person is then placed on a waiting list for an available bed. The waiting period ranges from as little as two months to as much as eighteen months depending on whether the “client” is waiting for availability in their facility of choice.

[195] The Community Urgent Request arises in a situation where a “client” who has already been panelled, is waiting for an available bed in a facility of choice and a change in circumstances occurs requiring a quick placement (e.g. sudden change in cognitive status; an inability to care).

[196] The Urgent Respite Request arises in a situation where a person, not known to the system or is known but not yet panelled, is in need of immediate placement. These types of requests often come from hospitals.

[197] Mr. McLeod entered the system and was placed at Parkview Place as a result of an Urgent Respite Request pending panelling.

[198] Ms. Dinicola described panelling as the formal process of reviewing applications for long term care and determining eligibility for placement.

[199] "Panel" sits every second work day. The assessment package is put together by the client's care coordinator and is presented to a two person panel either in person or by teleconference.

[200] Court heard that there are thirty-nine PCHs in Winnipeg, four of which accept urgent respite, including Parkview Place. Historically, the four homes which accept urgent respite have shorter waiting lists on a regular basis. In any event, a PCH always determines if it will accept a client, or not.

[201] Urgent Respite Requests take priority over other types of requests. It typically takes one to two days between the time an application is sent to a PCH on behalf of a client in need of urgent respite and a determination of admissibility by said care home.

[202] In October of 2010, Ms. Dinicola's office became aware of Mr. McLeod's circumstances through Réal Cloutier (Vice-President of Long Term Care). A request was made of her to gather information and determine what could be done in this regard. This led to an urgent respite application being prepared and a potential bed being located at Parkview Place.

[203] She recalled that a number of steps were being taken simultaneously so as to ensure that a solution could be found quickly. In fact, a pre-admission assessment by Parkview Place was being conducted prior to a determination by Long Term Care that Mr. McLeod was eligible for urgent respite. She testified that this was the first time she had ever seen the process unfold in such a manner.

[204] On October 8, 2010, Long Term Care confirmed Mr. McLeod's eligibility and Parkview Place confirmed that he was admissible.

[205] When questioned about the quick turnaround speed, Ms. Dinicola stated that she "would hope for this type of turnaround given the urgent nature" of a respite application.

[206] A PCH always makes the ultimate decision regarding admissibility. Eligibility is within the purview of Long Term Care. She stated that it is not uncommon for a PCH to deny admissibility if, for example, a person is not a good fit for a particular vacancy or for the facility in general. In some instances, particular issues of concern identified by a PCH, when denying admissibility, can be resolved and a rejection by a PCH could be reconsidered.

[207] Of significant interest to this inquest was questioning of this witness which revolved around the following issue, namely "if someone does not do well" in a PCH from a behavioural standpoint, what options are available?

[208] Answers provided were as follows:

- If the medical needs of a resident are greater than the PCH can address, the resident may be transferred to "Chronic Care".
- If the issues are "behavioural" based, an application could be made to TAP (which sits once a month) by the PCH for transfer to one of the "behaviour units" available in the City of Winnipeg. In this regard, the realities are as follows:
    - In 2011, there were only twenty-six behaviour units in Winnipeg:
        - Riverview – Fifteen units
        - Deerlodge – Eleven units
- There is a waiting period which could exceed six months for these behavioural units assuming the Transition Advisory Panel authorizes the transfer.
- In the interim, a PCH is tasked with finding a way to ensure safety of all; "behavioural mapping" and potential funding for "one-on-one" client supervision were identified as possible options in this regard.

[209] The Court heard that since 2011, nine "behaviour units" were added in Winnipeg, all at Actionmarguerite in Saint-Boniface. In all, the WRHA now has thirty-five behaviour units.

[210] A TAP application was not made by Parkview Place regarding Mr. McLeod, nor was funding for "one-on-one" client supervision.

J. Dr. Stanley Yaren

[211] Dr. Yaren is the recently retired Director of Forensic Psychiatry for the Province of Manitoba, a position which he's held since 1987. He was the Director of Psychiatry for the Province in 2010 and at all times material to the events surrounding this inquest.

[212] Dr. Yaren's responsibilities include preparing forensic reports and seeing accuseds at the WRC, a correctional facility or at the Health Sciences Centre (PX3). Depending on the severity of the issues, where a patient is seen, varies. Dementia is not common in terms of the work that is expected of a forensic psychiatrist. Typically, a forensic psychiatrist is dealing with individuals who are suffering from major mental disorders. He estimates that only approximately five percent of those he has seen in the course of his responsibilities were suffering from dementia.

[213] Dr. Yaren described that PX3 at the Health Sciences Centre is not designed to deal with and treat individuals with dementia.

[214] On April 7, 2011 he had his first contact with Mr. McLeod. The Court ordered Mr. McLeod's forensic assessment on March 28th, 2011; the same day he was admitted

to PX3. His assessment of Mr. McLeod was one of cognitive impairment. Mr. McLeod did not know where he was, what year it was, stating that "I usually get my wife to tell me those things". He stated that Mr. McLeod had no recollection of the events which had occurred or the nature of the charges that he was facing. He did not know who his family members were. Dr. Yaren observed irritability and agitation. Mr. McLeod was at PX3 from March 28, 2011 to May 30, 2011.

K. Greg Lussier

[215] Mr. Lussier is a case coordinator with "Home Care"- Transcona office . He is the main contact for a client when he or she is determined to be eligible for home care. These are not his sole responsibilities.

[216] In February of 2010, Mr. Lussier had contact with Mr. McLeod and his family. Both Mr. and Mrs. McLeod were present. Mr. McLeod made it clear that he wanted no assistance at home (the referral for Mr. Lussier's involvement came from Concordia Hospital and it was with a view to potentially being able to offer "respite" care). Mr. McLeod was cooperative in the context of this initial visit but was adamant that he did not want home care.

[217] From March 2010 to September of 2010, Mr. Lussier heard nothing from the McLeod family. On October 6, 2010, while Mr. McLeod was in remand custody at WRC, contact was re-initiated. A request was made, at that time, for a referral to a PCH.

[218] Prior to a referral to a PCH, he needed to be deemed "behaviourally stable". This was done by the Geriatric Mental Health Team.

[219] Once contact was re-initiated the file for Mr. McLeod was re-opened. Mr. Lussier met with Mr. McLeod (who was in shackles) and with his family at the Transcona Access Centre on October 7th. All were aware that Parkview Place might very well be an option available in the circumstances.

[220] Mr. Lussier testified that he had no access to any of the police reports when he was preparing Mr. McLeod's assessment reports for admission into a PCH.

[221] He further testified that Parkview Place was not in his view, a "concern" for Mr. McLeod's placement at the time, given his assessment.

L. Réal Cloutier

[222] Réal Cloutier is the Vice-President and Chief Operating Officer of the WRHA. In this capacity, he is a member of the Personal Care Home Leadership Council. This Leadership Council is comprised of the Executive Directors of the PCHs. They meet ten times a year. He speaks with the Executive Directors of the PCHs on a regular basis and addresses with them specific issues relating to their respective PCHs.

[223] Mr. Cloutier testified that patient flow (throughout the system) is his number one strategic priority. In other words, he wants to ensure that people are moving to the right place at the right time. He acknowledges that he sometimes becomes involved at the

ground level if things do not happen quickly enough. If people do not know exactly who to access, he intervenes. Flow management is key from his perspective.

[224] Mr. Cloutier acknowledges that Mr. McLeod belonged in a PCH and, in his view, the system fell apart when he was "stuck" at the WRC. As it relates to Mr. McLeod, Mr. Cloutier stated that it was in his purview to attempt to resolve this issue. No one told him that he had to do this; it was his role. He became involved and took steps to try to get Mr. McLeod into a PCH.

[225] On October 7, 2010, and after obtaining information regarding Mr. McLeod's circumstances, Mr. Cloutier spoke to Don Solar at Parkview Place. The purpose of the discussion was to determine whether a quick pre-admission assessment could be completed. Parkview Place is not an uncommon option for urgent respite or a fast PCH placement. Mr. Cloutier knew that Mr. Solar was aware of the "McLeod situation" because of media reports. Mr. Cloutier's comments to Mr. Solar were "If he is appropriate for PCH placement I need him moved as soon as possible."

[226] The turnaround with respect to the McLeod assessment and ultimate prompt placement to Parkview Place from WRC was fast but not uncommon. Mr. Cloutier indicated that this scenario was no different than someone who was in a hospital who did not belong there being moved to a PCH on a respite basis. It is not uncommon to get this move done within 24 hours.

[227] Mr. Cloutier confirmed that the WRHA has designed a process for individuals to access PCHs. The system is designed around need and not about who you know. It is to ensure fairness in the process and to ensure that there is no favouritism.

[228] He admitted that public pressure ultimately moved this matter along quickly. The entire transition from WRC to Parkview Place took less than 54 hours once the right people became involved. However, had Mr. McLeod not met the criteria for admissibility in a PCH, he would likely have remained at the WRC.

M. Gina Trinidad

[229] At all times relevant to the events, Ms Trinidad was the Executive Director of the Personal Care Program at the WRHA and had been acting in this capacity since November 2009. She currently holds the position of Chief Operating Officer of Long Term Care for the WRHA (amongst other positions).

[230] Her responsibilities ranged from general oversight of, amongst others, thirteen "for profit" PCHs, to monitoring standards, ensuring that PCHs follow through with "action plans" created for them and monitoring compliance with those action plans.

[231] She testified that "reviews" of PCHs such as Parkview Place are conducted every two years. PCHs are aware of these standard reviews and expect them. PCHs are also subjected to "unannounced reviews". Once a review is conducted, and if problems are identified, an action plan is created with a view to addressing them; time frames are set in this regard.

[232] Ms Trinidad testified that if PCHs are not compliant with action plans and "non-compliance" creates significant risk to clients, its licence could be placed under review. In such a case, families are informed of the problem and a transfer to another home could be requested on behalf of the resident. She has seen this happen two or three times during her tenure. She does not, however, recall a PCH losing its licence during her time at the WRHA.

[233] Parkview Place has had its licence under review on one occasion and this, after an "unannounced review"; this occurred following the events of March, 2011 and the death of Mr. Alexander. The facility's care plan did not, in a number of respects, correspond with what the staff was doing; mechanisms were not completely in place to deal with care plans and there was a need for further education of staff. Issues identified were ultimately corrected by Parkview Place and the "review" status was lifted in December of 2012.

CHANGES AND EXPECTED CHANGES IN SYSTEM SINCE 2011

[234] A large portion of Ms Trinidad's evidence addressed critical changes that have been implemented since 2011 and those which are expected in the future as a result of commitments by government.

[235] In 2011, there were only twenty-six "Special Needs Behaviour Beds" in Winnipeg (Eleven beds at Deer Lodge and fifteen beds at Riverview). A Special Needs Behaviour Bed requires double the funding of a regular bed given the increased need for staffing. In 2011, the waiting list for such a bed was six to twelve months.

[236] Since 2011, there have been plans to create space for nineteen more Special Needs Behaviour Beds in Winnipeg.

- Ten beds at Deer Lodge
- Nine beds at Actionmarguerite

[237] Manitoba Health has made recent changes (implemented in January, 2015) to its review process to include, as part of its assessment, an analysis of the staffing ratios within PCHs.

[238] There are new systems and protocols in place directing PCHs to report issues and occurrences involving individuals with challenging behaviours to Ms Trinidad's office so as to inform and seek assistance in dealing with or addressing problems of potential significance, namely:

- Communicating directly (email or telephone) with Ms Trinidad's department;
- PCHs tracking occurrences through their own on-site data base. The tracking at Parkview Place was previously done manually. Of note, Ms Trinidad is not aware of either occurrence reports or critical occurrence reports being received by her office regarding Mr. McLeod during his stay at Parkview Place. She would have expected to receive an occurrence report for certain of the incidents involving Mr. McLeod.

[239] Certain changes have since been made to the TAP process. Previously, TAP was the "be all-end all" avenue for all "non-panel" type of applications; whether it was for individuals with dementia, or not. Since 2011, changes have been made to the TAP process so as to ensure that the people who are coming to TAP are individuals in need of long term care or bound for long term care. In this regard, a coordinator has been assigned to "triage" potential applications before coming to TAP ensuring that persons applying to TAP are appropriate for long term care as opposed to persons who might more appropriately benefit from other resources which might better meet their needs.

[240] There are plans to increase bed capacity in Winnipeg by a further three hundred and forty; this amount is to include sixty Special Needs Behaviour Beds.

N. Christopher Ainley

[241] Mr. Ainley, current acting Director of Health Services for Corrections was, in 2011, the Health Services Manager at the WRC. His responsibilities included overseeing all health care in the facility.

[242] The WRC is equipped with a medical ward on its third floor. This medical ward has five observation beds (most often used for accused persons with acute medical issues or who may be suffering from alcohol or drug withdrawal) and eight double bunk cells (most often used for accused persons in need of protective custody, persons needing to be hidden from the institution's general population or individuals with medical issues which are not acute in nature). All, except for one of the observation beds, are monitored by camera.

[243] In the fall of 2010, Mr. McLeod was admitted to the WRC. As is the case with all new arrivals, there is a requirement that the accused see the nurse immediately upon admission. The nurse was apprised of the fact that Mr. McLeod had Alzheimer's disease and other medical conditions.

[244] In light of Mr. McLeod's circumstances, his stay at the WRC in the fall of 2010, was on the medical ward. He had very little contact with the general population. The medical unit is locked.

[245] Mr. McLeod had access to the recreational area and to the chaplain of the facility at times different than persons on other units in the facility. Court was told that he had access to a common area and, more importantly in his case, easier access to medical staff.

[246] The WRC medical personnel has access to an individual's medical records for medicinal purposes. They also resort to contacting family regarding prescriptions if need be. Medication is administered by the staff in the medical unit.

[247] In terms of medical personnel, the unit has 1.5 correctional psychiatric nurses. A contract physician attends the WRC five times per week. In addition, there are three "psychiatric clinics" per week, during which the court ordered assessments are conducted.

[248] Mr. Ainley testified that he had very little contact with Mr. McLeod during his stay at WRC. He gave him his medication on a few occasions.

[249] All inmates have both an ‘offender record” (in which behavioural issues are documented by a correctional officer) and a “medical record” (in which medical related issues are documented). As it relates to Mr. McLeod, Mr. Ainley testified that, other than refusing his medication on a couple of occasions (which issues were resolved by the staff returning to see him later) and refusing to return his meal tray on occasion, he did not note any other behavioural issues. There were no reports of self harm or of harm to others. Mr. McLeod was released from the WRC on October 8, 2010 and taken directly to Parkview Place.

[250] The WRC is not equipped to handle an individual with dementia in terms of appropriate health care. Mr. McLeod’s well being was better suited in another facility. He was safe when in remand custody; however, he was living in a “box”.

VI. RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

INTRODUCTION

[251] There are more than 500,000 people living in Canada with Alzheimer's disease. By 2030, there will be more than 1.1 million people in Canada affected by this disease and the number of persons in long term care in our country will have increased tenfold.

[252] When reviewing this report, we cannot lose sight of the fact that many of its recommendations are inextricably related. It is difficult, if not impossible, to envision the implementation of certain recommendations without implementing others.

[253] The Court also recognizes that the focus of these events and the resulting recommendations revolves around the City of Winnipeg. These recommendations, however, are, in large part, applicable Province wide. This is not solely an urban concern.

[254] Following a review and analysis of the evidence communicated to this Court in this inquest, it is evident that there is a clear under appreciation of the degrees of complexities when dealing with persons with dementia generally and Alzheimer's disease specifically.

Behavioral Units

[255] There must be a substantial increase in the number of beds dedicated to people with violent or aggressive tendencies. The Court heard evidence that the WRHA is creating new capacity. However, The Court also heard evidence that, at present, there are in excess of forty individuals in Winnipeg who are on a waiting list for placement in a high-risk bed. The Court also heard evidence that the number has increased in the last four years. In light of the demographic realities which our society is facing, the numbers of persons affected will increase drastically.

[256] Evidence is clear that the queue for these behavioral units can be as much as one year in length. This is not acceptable. The Court recommends that the WRHA and the Department of Health increase the number of behavioral units in order to ensure that the maximum wait for such a bed be no more than 60 days.

[257] The Court recognizes that there is limited funding that can be provided to the healthcare system. There is only so much money that can be spent on the construction of new facilities. As a result, creative solutions must be found to accommodate persons with violent/aggressive tendencies. One of those solutions is found in Ms Trinidad's report of March 31, 2011 following the review of Parkview Place after March 24, 2011. Parkview Place is an institution that has a capacity for 277 residents. It has 13 floors. Ms Trinidad recommended that Parkview Place take steps to create a ward that would be dedicated to violent/aggressive individuals. This ward would be locked so that those individuals would not have the ability to wander throughout the facility. The Court also heard evidence that units for violent/aggressive individuals must be relatively small in order to lessen the opportunity for "patient to patient" conflict. All facilities should have this capacity to address urgent circumstances of the sort described. There must be a

solution when all other methods fail and pending alternative placement in an appropriate facility.

[258] The Court recommends that the WRHA and the Department of Health be directed to work with all PCHs to create a unit within each PCH to address the needs associated with persons exhibiting violent and aggressive behavior. If every PCH provided a unit dedicated to these patients, there would be a significantly greater chance that these individuals would be properly cared for and that the system would be safer for all, including the residents and the staff.

Home Care

[259] Mr. McLeod was left out of the system once his file was closed, and following a refusal to benefit from the support the system was prepared to offer.

[260] A system needs to be designed to track these types of situations so as to regularly follow-up with individuals afflicted by dementia and who refuse assistance, as was the case with Mr. McLeod.

[261] Once Mr. McLeod was back in the system, no one really seemed to know what to do with him, nor did they obtain relevant and apparently available information regarding his circumstances. This is evidenced by his one month stay at the WRC. There is a definite need for better communication amongst all of the stakeholders.

[262] The evidence disclosed how the family attempted to obtain home care assistance for Mr. McLeod. The family is most often in the best position to see the decline of one of its members affected by dementia. Faye Jashyn took the proper steps to assist her parents. Unfortunately, Mr. McLeod refused this assistance. Ms Jashyn made, what turned out to be an ominous prediction that turned out to be true; that something bad would have to happen before steps would be taken to assist her father. She was correct, and the result was the unfortunate attack upon Rose McLeod, and ultimately upon Frank Alexander.

[263] We are faced with a difficult dilemma. Mr. McLeod had the right to turn down assistance. On the other hand, as we know from the evidence from Dr. Campbell, dementia prevents a person from comprehending their true capability and robs the person of the ability to make proper choices.

[264] What we did learn was that if home care is declined, the file is closed and no further contact is made with the family. The Court's recommendation is that once a request has been declined, that the home care office leave the file open to be revisited (by the home care coordinator) every three months in order to determine whether matters have worsened, thereby making home care a necessity. It is the Court's view that had this taken place in this case, the McLeod family would have had the opportunity to have addressed their father's worsening condition prior to the attack upon Rose McLeod. We cannot lose sight of the fact that this is a disease which progresses rapidly.

[265] One cannot underestimate the potential role of the home care coordinator and the value of the advice and follow-up potential they have to offer.

Winnipeg Remand Centre

[266] Mr. McLeod was placed in the WRC after the assault of Rose McLeod. The evidence presented at the inquest suggests that it was as if Mr. McLeod fell into a deep, dark hole as far as the healthcare system was concerned; until Mr. Gerrard held his press conference.

[267] The Court recommends that the Department of Health develop a protocol with the Departments of Justice and Corrections to accommodate persons charged with criminal offences who are suffering from dementia. There must be a coordinated approach between these departments. That protocol ought to address where such an individual should be housed, how such a person should be assessed (both from a healthcare perspective and from a justice perspective) and what arrangements could be made to accommodate both the healthcare and justice systems.

[268] The protocol should require that any assessment undertaken for the healthcare system include a review of the records from the WRC. In the Court's view, there must be a recognition that a person housed in the WRC, accused of a violent crime, may well not be suitable for a regular placement in a PCH. Any assessment undertaken for a PCH must take into consideration the full details of the incident in question. The evidence in this inquest confirms that not all decision makers involved were aware of all of the salient facts of his incarceration. As an adjunct to this recommendation, the WRC records must be provided and reviewed by a PCH when making its assessment of the suitability to be admitted to a PCH.

[269] There needs to be a better interplay between the legislation that governs privacy and the need of coordination to access vital information on a timely basis. Certainly there are privacy concerns to be considered but there are also safety and appropriate placement concerns that need to be addressed.

[270] As a further part of this recommendation, the issue of assessment by the WRHA for a violent/aggressive person ought to be undertaken by a specialized panel. The Court heard evidence about the TAP Panel. It is the Court's recommendation that this panel be the required assessor of persons coming into the PCH system with known aggressive/violent tendencies.

Personal Care Homes

[271] It is not lost on the Court that health care aides in PCHs have the most "hands on" interaction with residents. Training in this regard for all staff must be mandatory.

[272] The Court recommends that PCHs be mandated to increase the scope of training for **all** staff who have interaction with residents so as to include mandatory training in dealing with violent/aggressive individuals. This training needs to be repeated regularly. The Court heard much evidence regarding P.I.E.C.E.S.. For the safety and protection of all staff and all residents, this training ought to be mandatory, uniform and ongoing. Further, the Court heard from Dr. Campbell that understanding the various stages of Alzheimer's disease could assist PCHs and the staff in better appreciating the

complexities of dealing with their residents. Education in this regard for all staff must also be mandatory.

[273] The Court recommends that PCHs be required to develop a safety protocol to protect patients and staff from acts of aggression from violent patients. The protocol ought to include strategies that would include the following:

i. a determination of when a patient should be placed in a secure unit;
ii. when a patient should be prevented from wandering unrestricted throughout a facility;
iii. a protocol to alert other staff when a person is refusing medications;
iv. a protocol for requiring intervention by a physician or psychiatrist when a person is refusing medications; and
v. a protocol to ensure that knowledge of violent/aggressive incidents is brought to the attention of all staff, including management, supervisors and floor staff.

[274] Ms Trinidad made a number of recommendations that bear consideration. In her review of Parkview Place, she recommended that certain steps be taken. It is the Court's view that the recommendations made by Ms Trinidad ought to be considered by the system as a whole. Ms Trinidad recommended:

a) There must be a process to track aggressive incidents in order to permit a quick response by a facility;
b) There must be a process that requires a PCH to notify the appropriate Access Centre when it cannot safely manage a resident's care;
c) There must be a requirement that nurses receive greater training regarding psychotropic drug use and maintenance of appropriate therapeutic levels;
d) There must be a process to notify physicians when a patient is not taking medications;
e) There must be a secure unit that prevents aggressive patients from wandering; and
f) There must be appropriate supervision of residents.

[275] The Court heard evidence from Mr. Roos from his time at Parkview Place regarding the behaviour of Mr. McLeod. When asked about moving Mr. McLeod out of Parkview Place to a more secure environment, Mr. Roos spoke of the lengthy time process that was involved in making an application to TAP. The Court recommends that a direction be given to the WRHA that the TAP Panel be scheduled to meet twice monthly and that there be a requirement that a hearing by the TAP Panel be convened within a period of 35 days from the date of application. This would ensure that these applications are dealt with in an expedited fashion in recognition of the potential danger posed by violent/aggressive individuals. It would also ensure that field workers such as Mr. Roos would have the confidence to know that their concerns would be addressed in an expedited fashion.

[276] Ms Trinidad noted that Parkview Place never applied for one-on-one funding to assist in the care of Mr. McLeod. The Court recommends that a protocol be developed that would require a PCH to apply for one-on-one funding when an appropriate level of violent/aggressive incidents have taken place and that other methods of behavioral intervention have failed. This protocol would also require that the WRHA intervene in a PCH when occurrence reports have been received regarding an individual that exceeded the accepted levels of violent/aggressive incidents.

[277] The protocol for dealing with violent/aggressive individuals ought to include a clear statement that all staff at a PCH home have the right to contact the local police force to assist in care of violent behaviour by a resident. Any attempts by a PCH to limit or to prevent staff from contacting the police must be barred.

[278] During this inquest, the focus was on the number of incidents of violent/aggressive behavior exhibited at Parkview Place by Mr. McLeod. The Court recommends that an automatic review of the suitability of a resident be undertaken by management each time that such an occurrence is reported. This would assist management in assessing the suitability of residents for the PCH.

[279] Measures must be taken to ensure that staff have the ability to report dangerous situations immediately within the facility. In some PCHs, all staff are supplied with “code white” buttons that allow staff to report emergency situations immediately.

[280] A protocol should be developed to assist the public in better understanding a PCH environment. This protocol would address issues such as safety and the reality of the varying degrees of mental competence one would expect to encounter in a PCH.

Police Services

[281] Police forces cannot be expected to “care” for persons afflicted by dementia. That said, they should give some consideration to incorporating an educational component into their respective training programs relating to dealing with persons afflicted by dementia.

[282] The Court makes this suggestion concluding that there is nothing that the police involved in this particular case, could have done differently.

Dated at the City of Winnipeg, in Manitoba, this 26th day of May 2015.

_____

Judge Michel Chartier

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: FRANK ALEXANDER

EXHIBIT LIST

Description

1. Hansard - Legislative Assembly of Manitoba
2. Parkview Place Status Update Report related to unannounced review following March 24, 2011
3. Map of Parkview Place
4. Series of occurrence reports Re: Mr. McLeod
5. Map of Recreational Area of Parkview Place
6. Record of Proceedings, Recognizance, and Information of Mr. Joseph McLeod
7. Curriculum vitae – Gina Trinidad
8. Hard copies of documents (8 Black Binders) with CD