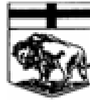
RELEASE DATE: June 26, 2015



Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

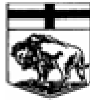
AND IN THE MATTER OF: An Inquest into the death of:

JAMES LIVINGSTON
(DATE OF DEATH: April 19, 2012)

Report on Inquest and Recommendations of
Judge Robin Finlayson
Issued this 23rd day of June, 2015.

APPEARANCES:

C. Savage, Crown Counsel
D. Ryall, Associate General Counsel, Winnipeg Regional Health Authority
Helga Van Iderstine, Aikins, MacAulay & Thorvaldson, counsel for Dr. Adrian Hynes and Dr. Randy Goossen, Health Sciences Centre, Winnipeg



Manitoba

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

REPORTED BY A PROVINCIAL JUDGE ON AN INQUEST

RESPECTING THE DEATH OF JAMES LIVINGSTON

Having held an Inquest respecting the death of JAMES LIVINGSTON on January 19 – 21 and January 23, 2015, at the City of Winnipeg, in Manitoba, I report as follows:

The name of the deceased is: JAMES LIVINGSTON

JAMES LIVINGSTON came to his death on the April 19, 2012, at the City of Winnipeg, in the Province of Manitoba.

The cause of death was hanging.

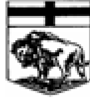
I hereby make the recommendations as set out in the attached report.

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 23rd day of June, 2015.

Original signed by:

Robin Finlayson.
Provincial Court Judge



Manitoba

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

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

JAMES LIVINGSTON

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I. DISTRIBUTION LIST:

1) Dr. T. Balachandra, Chief Medical Examiner
2) Chief Judge Ken Champagne, Provincial Court of Manitoba
3) The Honourable Gord Mackintosh, Minister Responsible for *The Fatality Inquiries Act,* Minister of Justice and Attorney General
4) Ms Donna Miller, Q.C., Deputy Minister of Justice and Deputy Attorney General
5) Mr. Michael Mahon, Assistant Deputy Attorney General, Prosecutions Division, Manitoba Justice
6) Ms Jacqueline St. Hill, Director, Winnipeg Prosecutions
7) Ms Lorraine Prefontaine, Director, Specialized Prosecutions
8) Mr. Russ Ridd, Director, Regional Prosecutions
9) Ms Colleen McDuff, Director, Legal Education & Appeals
10) Dr. C.D. Littman, Medical Examiner and Pathologist
11) Mr. C. Savage, Crown Counsel
12) Mr. Dan Ryall, Associate General Counsel, Winnipeg Regional Health Authority
13) Ms Vivian E. Rachlis, Senior Associate General Counsel, Winnipeg Regional Health Authority
14) Dr. Laura Calhoun, Health Sciences Centre
15) Dr. Adrian Hynes and Dr. Randy Goossen, represented by Helga Van Iderstine, Aikins, MacAulay & Thorvaldson
16) Exhibit Officer, Provincial Court of Manitoba
17) Ms Aimee Fortier, Executive Assistant and Media Representative, Provincial Court of Manitoba

II. MANDATE OF THE INQUEST

[1] 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.

[2] 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.

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

III. THE CALLING OF THIS INQUEST

[4] The Chief Medical Examiner for the Province of Manitoba, Doctor A. Thambirajah Balachandra, sent a letter bearing date March 22, 2013 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 JAMES LIVINGSTON for the following reasons:

1. to fulfill the requirement for a mandatory inquest as defined in section 19(3) of the legislation;

2. to determine the circumstances relating to Mr. Livingston's death; and

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

[5] 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.

IV. PRELIMINARY COURT PROCEEDINGS

A. STANDING

[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. Standing Hearings were held on November 25, 2013.

[7] On Monday, November 25, 2013, standing was granted to:

1) Winnipeg Regional Health Authority, represented by Dan Ryall, Associate General Counsel, Winnipeg Regional Health Authority

2) Dr. Adrian Hynes and Dr. Randy Goossen, represented by Helga Van Iderstine, Counsel with Aikins, MacAulay & Thorvaldson

3) Canadian Mental Health Association (CMHA) represented by a designate chosen by George Passieka, Executive Director of the CMHA Manitoba Division.

[8] No further individuals or organizations made application for standing.

V. SUMMARY OF EVENTS AND AUTOPSY LEADING UP TO THIS INQUEST

A. SUMMARY OF EVENTS OF APRIL 19, 2012.

[9] In April 2012 Mr. Livingston was 68 years of age, a resident at the Health Sciences Centre where he was being held under *The Mental Health Act.*

[10] On April 19, 2012, during rounds, a nurse was unable to open the door to Mr. Livingston's room. She pushed the door against resistance and found Mr. Livingston on the floor, supine, with blood smeared under his head and a belt around his neck. A "code blue" was called at 19:20 hours however resuscitation was unsuccessful and Mr. Livingston was pronounced dead at 19:42 hours. Subsequently, the body of Mr. Livingston was wrapped and removed to the hospital morgue.

B. SUMMARY OF AUTOPSY REPORT RE: CAUSE OF DEATH

[11] A medico-legal autopsy conducted on June 12, 2012, ultimately confirmed that Mr. Livingston died as a result of suicide.

VI. WITNESSES FOR THE INQUEST

A. Dr. Adrian Hynes

[12] Dr. Hynes is a psychiatrist in Winnipeg and also the Director of the Co-occurring Disorders Program in the Health Sciences Centre for The Winnipeg Regional Health Authority. Specifically, Dr. Hynes works on Ward PX2 at the Health Sciences Centre. He advised that Ward PX2 deals with patients with significant mood disorders and also patients who have co-occurring disorders. There are 21 beds in PX2 and 3 psychiatrists assigned to the ward.

[13] On March 21, 2012, Dr. Hynes advised that Mr. Livingston arrived on PX2 after stops in Internal Medicine and PY3 South. Mr. Livingston initially entered the hospital through emergency and was then transferred to PY3 South which is the Intensive Care Psychiatric Unit. It was determined that he did not require intensive psychiatric attention and therefore on April 6, 2012, he was transferred into PX2 with a diagnosis of bipolar disorder, manic episode.

[14] According to Dr. Hynes, he knew Mr. Livingston from previous dealings and according to Dr. Hynes, his diagnosis was more properly described as alcohol amnesia disorder or Korsakoff's syndrome. Korsakoff's disorder arises as a result of drinking too much alcohol over such a length of time that it affects your brain such that your memory gets severely damaged. In fact, in Mr. Livingston's case, his short term memory was gone. In Dr. Hynes opinion, Mr. Livingston would have had to consume approximately 10 standard drinks a day for 20 years before getting Korsakoff's syndrome.

[15] Dr. Hynes testified that with Korsakoff's, an individual cannot remember what they had for breakfast a few hours earlier or as in Mr. Livingston's case, cannot remember where his room was located. Dr. Hynes also testified that there is no correlation between Korsakoff's syndrome and suicide. Dr. Hynes testified that if Mr. Livingston had been diagnosed with Korsakoff's during his stay in the Internal Medicine Department, he would not have been transferred to the psychiatric ward. However,

because he had been transferred to PX2, he could not be transferred back to Internal Medicine as there was no treatment available for someone with Korsakoff's. Dr. Hynes also testified that with abstinence some of the symptoms associated with Korsakoff's might improve. However, Mr. Livingston suffered from a severe enough form of Korsakoff's that he could not remember talking to Dr. Hynes five minutes after speaking to him.

[16] With respect to the incident of April 15, 2012, where Mr. Livingston had been found with a belt loosely around his neck, Dr. Hynes indicated that he did not become aware of this incident until after Mr. Livingston's death. Dr. Hynes testified that he did not see the notation concerning this incident in the daily progress report. He testified that he did attend the Monday morning Kardex meeting which is a review of all of the incidents concerning the patients on PX2 but he did not recall the belt incident concerning Mr. Livingston being raised at the April 16th meeting.

[17] Dr. Hynes testified that if he had known about the April 15th incident he would have spoken to Mr. Livingston about it and he would have placed him on close observation for 48 hours. After that Mr. Livingston would have been given back his clothes including his belt. With close or suicide observation, patients are checked every 15 minutes as opposed to every couple of hours.

[18] Dr. Hynes testified that he also saw Mr. Livingston on April 18, 2012 with respect to a renewal request. Mr. Livingston did not want to stay in the hospital but according to Dr. Hynes, Mr. Livingston was at significant risk of deterioration and he did not have any housing in place. Therefore, Dr. Hynes testified that he signed the renewal certificate. This certificate extended Mr. Livingston's involuntary stay in hospital for a further 3 months.

[19] With respect to Mr. Livingston's death, Dr. Hynes did express surprise that Mr. Livingston would remember the complicated procedures required for him to commit suicide given his loss of executive functioning. Dr. Hynes did not believe that Mr. Livingston would have remembered the episode from April 15th when he was found with a belt around his neck. Dr. Hynes did proffer that in terms of doing something so complex, the physical memory of his work as a paramedic could have remained with Mr. Livingston for a long period of time.

[20] Dr. Hynes did indicate that the longer term plan for Mr. Livingston was to find him suitable housing in Winnipeg with home care and a group home supervisor.

[21] Dr. Hynes testified that while under his care, he tapered Mr. Livingston off 2 medications, clonazepam and dilantin phenytoin, both of which had been prescribed for a bipolar disorder diagnosis and both of which impacted on cognitive functioning. These medications had been discontinued by April 18th, the day before his death. Mr. Livingston was prescribed quetiapine by Dr. Hynes to help him sleep.

[22] Through counsel, Dr. Hynes introduced a document entitled occupational therapy functioning assessment summary report. This assessment was conducted on the morning of April 16 and April 18, 2012. In that assessment the occupational therapist, Nancy Klikke wrote:

> "Through discussion about the reason for his admission, James Livingston stated he was not intending to kill himself as he would never do that. James expressed he was upset with being evicted and he was requesting for the team to advocate on his behalf, to be able to return to his residence."

[23] In addition, there were other indications that Mr. Livingston was future oriented. For example, on March 29th he indicated that he wanted to be discharged to a pet friendly place.

[24] Dr. Hynes testified that psychiatry reviewed with Mr. Livingston that he was dementing on April 2, 2012; that in fact he was getting worse, and he was accepting of this news. Further Dr. Calhoun noted that "he will need to be panelled in order for him to be placed in a care home". In this regard, it appears initial steps were being taken to place Mr. Livingston into a long term care access center.

[25] Dr. Hynes also testified that on April 4, 2012, a physician assistant saw Mr. Livingston and again a notation was made that there was no indication of suicidal intent.

[26] Dr. Hynes also testified that it was a common theme for Mr. Livingston to persevere on the notion of going out for a smoke, at times bothering staff on an hourly basis in this regard. This was a huge issue for staff as they would have to accompany Mr. Livingston outside of the Health Sciences Centre building and at least 10 meters away each every time he wanted to go out for a smoke.

[27] On April 12, 2012, Mr. Livingston presented at the front desk in a very agitated state. He was very angry after receiving a letter regarding a certificate of capacity. Also on April 13, 2012, the hospital was advised that Mr. Livingston had been evicted from his rooming house effective April 1, 2012.

[28] On April 15, 2012 at 06:40 a.m. Mr. Livingston was at the nursing station after having been given some medication (5 mg. clonazepam) at approximately 04:45 a.m. At 07:00 a.m. Mr. Livingston was directed to change his clothes and shower.

[29] At 07:30 a.m. Mr. Livingston was seen on video monitoring placing his belt loosely around his neck and proceeding to enter the washroom. The nurse then entered the room and the washroom and removed the belt as well as a chair. Thereafter Mr. Livingston became agitated, irritable and boisterous. Dr. Hynes agreed that what Mr. Livingston fixated on was not the belt but his loss of smoking privileges.

[30] At approximately 3:30 p.m. on the same date there was a note made that the patient had a more settled day, responding well to positive reinforcement with no voiced suicidal ideation or gestures made on his behalf during the day. Again at 11:10 p.m. there is a note that Mr. Livingston appeared calmer and was able to engage in conversation with staff in a respectable, calm, manner.

[31] On April 16, 2012, Dr. Hynes testified that Mr. Livingston was seen by a social worker who noted that he seemed more behaviourally settled on the unit. Dr. Hynes saw the patient again on the April 18th and noted that he was focused on his demands and quickly forgets his refusals.

[32] On the morning of April 19, 2012 Mr. Livingston was found pacing his room, swearing to himself and stating that his needs were not being met. At 03:00 a.m. authority was given to prescribe one (1) mg. of ativan to Mr. Livingston.

[33] On April 19th at 12:20 p.m. Mr. Livingston was given a copy of the renewal of the involuntary admission after he declined to sign same. At 6:00 p.m. the nurse noted that Mr. Livingston spoke of interest in having a haircut on the Monday by the unit assistant. Also, Mr. Livingston engaged with the nurse regarding his interest in western books. There was no indication of suicidal intent according to her.

[34] Dr. Hynes also testified that a new Observation Form ("OBS") has been introduced to track patients who are on close or suicidal observation. This new form shows exactly where they are and what they are doing in more detail at any given time.

[35] Dr. Hynes testified that during the time Mr. Livingston was in his care at PX2 he did not have any concerns about him being suicidal. Dr. Hynes further testified that he attended the hospital after learning of Mr. Livingston's death to provide whatever information or assistance he could provide to the physician on call.

B. Dr. Randolph Goosen

[36] Dr. Goosen is a psychiatrist who initially practiced family medicine in Manitoba. In 1994 he graduated from The University of Western Ontario as a psychiatrist.

[37] Currently Dr. Goosen is the Medical Director of Community Mental Health for The Winnipeg Regional Health Authority and also for the University of Manitoba and accordingly he spends part of his time at the Psych Health Building at the Health Sciences Center.

[38] Dr. Goosen testified that he was working seeing patients on the evening of April 19, 2012 on the same floor as ward PX2 when he heard a blue code, which usually means that somebody's heart has stopped and requires resuscitation.

[39] Dr. Goosen indicated that PX2 was still a considerable distance from where he was located but he felt he should attend as part of his professional obligation.

[40] Dr. Goosen testified that when he arrived on the ward (PX2) he was directed to a room where he found a body on the floor with the person's feet partially behind the door to the room, and his head pointing away from the door. According to Dr. Goosen, the patient did not appear to be breathing.

[41] Dr. Goosen testified that after an assessment, an AED (Automatic External Defibrillator) was brought into the room. This is a device which Dr. Goosen is familiar with using on patients in similar circumstances. According to Dr. Goosen however, although the device was used it did not prompt for a shock to be administered to Mr. Livingston.

[42] Dr. Goosen also testified that he asked for an airbag to facilitate oxygenation and one was received and applied.

[43] Dr. Goosen testified that the intensive care team did attend and they took over the resuscitation of Mr. Livingston after approximately 10 minutes.

C. Phil Kwan

[44] Nurse Phil Kwan began working on PX2 in April 2012 after his graduation. Mr. Kwan testified that there are 3 work shifts at PX2 and that there would be 4 nurses on each of the day and evening shifts and 2 nurses on the night shift. On the weekends it would change to 3 nurses for the day and evening shifts. During the day and evening shifts nurses are assigned to particular patients while during the night shift both nurses take care of all patients.

[45] Mr. Kwan indicated that at the beginning of his shift he would listen to reports of the shift which had been recorded by the "charge nurse" before the end of the previous shift. Mr. Kwan also indicated that there are integrated progress notes prepared on each patient that are kept behind the front desk and that he would also review these reports.

[46] Mr. Kwan testified that on April 15, 2012, Mr. Livingston was on PX2 in a 'camera room' with the video screen being located at the nursing desk. At approximately 07:30 a.m. Mr. Kwan observed Mr. Livingston with a belt loosely around his neck with his arms at his side and he was walking in and out of his bathroom.

[47] Mr. Kwan testified that he attended to Mr. Livingston's room and took the belt off Mr. Livingston's neck and asked him a series of questions and then told him they were going to take the belt away for safety. Mr. Kwan testified that when they approached Mr. Livingston, he appeared almost dissociative and he was very calm. Nurse Kwan asked Mr. Livingston if he was suicidal and he replied no. Mr. Kwan also testified that they found the chair from Mr. Livingston's room in the bathroom so they took it out of the room completely.

[48] Mr. Kwan testified that about 10 minutes later Mr. Livingston presented at the front desk in an agitated state. At first he was demanding his belt back but he then proceeded to persevere about his smoking privileges. Mr. Kwan testified that he then reported the incident to the designated "charge nurse". Mr. Kwan said he also spoke to the "charge nurse" about changing Mr. Livingston's status to close observation or every 15 minutes and he believed that had been done. Mr. Kwan also remembers speaking to 1 or 2 nurses who were coming on shift regarding the incident with Mr. Livingston.

[49] Mr. Kwan also testified that if someone was placed on close observation, he would probably be seen by a physician the next morning and the patient would be re-assessed within 48 hours.

D. Tara Regiec

[50] Ms. Regiec is a nurse with approximately thirteen and one half years experience. Ms. Regiec was the designated "charge nurse" on the evening of April 15, 2012 when the belt incident occurred with Mr. Livingston.

[51] Ms. Regiec indicated that as a result of the belt incident, she verbally alerted the next "charge nurse" that came on duty about this event. She also testified that she thought the new designated "charge nurse" would change Mr. Livingston's status to close observation as a result of the belt incident. In this regard she testified that the change in observation status would normally have been noted on the rounds log, the Kardex, the menu card, the observation chart, the progress report and potentially a whiteboard which is maintained in the office behind the front desk. Ms. Regiec had no further direct dealings with Mr. Livingston up until the time of his death. However, she did see him back in his clothes the day before he died.

[52] Finally, Ms. Regiec testified that other nurses on the next shift could change Mr. Livingston's observation back to routine without the permission of a medical physician as it had been a nursing decision to direct close supervision of Mr. Livingston.

[53] Ms. Regiec was also aware that a new observation record had been created for the unit to provide more detail about what observations were occurring in regards to specific patients.

E. Cynthia Watson

[54] In April 2012 Ms. Watson was employed as a nurse 2 on general duty and assigned to ward PX2 at the Health Sciences Center. As of April 2012 she had roughly three and one-half years experience. Ms. Watson started work on Sunday, April 15, 2012 at 07:30 a.m. and she began by listening to the tape recording of the night's events.

[55] Ms. Watson testified that during the briefing she was verbally advised by nurse Tara Regiec that one of the patients, Mr. Livingston, had been found in the hallway with a belt around his neck, that he had soiled himself and he was distressed. She indicated that she was Mr. Livingston's assigned nurse for the day but she could not recall what level of observation he was on. She testified that she would have reviewed his medical record or MAR at the start of her shift as she would have done for all of the patients assigned to her. She could not recall looking for Mr. Livingston's observation status or whether she actually saw it. She said she may have also reviewed his Kardex and the whiteboard in the charting room but again she could not recall.

[56] Ms. Watson did testify that at the end of her shift, she did document that Mr. Livingston was on nursing close observation as she just became aware of this fact near the tail end of her shift. For most of her shift she did not know or could not recall that Mr. Livingston was on close observation.

[57] Ms. Watson testified that at the beginning of her shift Mr. Livingston was quite boisterous but he settled down and sat in the day lounge talking with other patients. She said that he spent most of the day in the common area of the ward, so in fact he was not being checked on every 15 minutes as would otherwise be required. Ms. Watson did not recall whether Mr. Livingston was wearing a belt nor did she recall him asking for it to be returned to him. Ms. Watson testified that based upon her observations she had no concerns with respect to self harm on the part of Mr. Livingston.

F. Shannon Schofield

[58] Ms. Schofield has been a nurse at the Health Sciences Center since 1998 and has been nurse supervisor since 2008. In 2012 she was the nurse supervisor responsible for ward PX2. Ms. Schofield testified that she did not know about the belt incident involving Mr. Livingston until after he had died.

[59] Ms. Schofield testified that she was working the day Mr. Livingston died. She had attended PX2 earlier in her shift and everything had been fine. Later she heard a code for PX2 and immediately attended back there. Ms. Schofield attended Mr. Livingston's room and took over performing CPR on him. She testified that it took the immediate response team a little longer to respond because the tunnels were closed and that cost them some extra time. However, they did arrive and took over the CPR.

[60] Ms. Schofield testified that in terms of noting the observation level of different patients it is the Kardex that should be the first point of reference and the whiteboard for quick reference. Ms. Schofield noted that the Kardex should be updated every shift. Ms. Schofield also testified that if the observation status on a patient changed during a shift then the various documents – the Kardex, the progress notes, the whiteboard, should all be updated within the shift. Ms. Schofield agreed that it would be a practical solution to assign to the "charge nurse" the responsibility of updating the observation

level of each of the patients on each of the documents (i.e.: Kardex, progress reports, whiteboard) before the end of the shift.

[61] Ms. Schofield also testified that it would be a good idea for the "charge nurse" to initial the whiteboard in terms of what time it was last updated. Ms. Schofield also testified that as each of the documents being used on the ward has a different purpose, (i.e. the whiteboard, the Kardex, the progress notes, the observation sheet) and therefore they should all be maintained and updated. She testified that if something occurred with a patient she expected a doctor would see the patient much sooner than within 48 hours.

[62] Ms. Schofield testified that she did not see the shift change as a reason for the various documents being overlooked as staff is able to obtain approval for overtime very easily in order to update these records.

VII. OTHER EVIDENCE

[63] The court notes that two nurses who would have been called as witnesses were not available and accordingly statements from each of these witnesses, Katherine White and Michelle Gabrielle, were filed as agreed statement of facts by counsel who were granted standing at this inquest.

[64] Ms. White was working on April 19, 2012 although Mr. Livingston was not assigned to her as one of her patients. While covering for one of her fellow nurses who was on a break, she entered Mr. Livingston's room and found him lying on his back with a belt secured tightly around his neck. She stated that Mr. Livingston's eyes were open, his face was pale and his hands were cold. She did not observe the patient's chest to rise and fall and he did not respond to his name. Ms. White stated she left the room to call for a code blue and then returned to the room and removed the belt from Mr. Livingston's neck. She left the room again to obtain the blue cart. She was present when Dr. Goosen started chest compressions. She also applied the AED pads to Mr. Livingston's chest. Ms. White also called for a second code blue as remaining members of code blue team had not arrived with the cart. She then assisted with re-directing other patients on the ward.

[65] Ms. Michelle Gabrielle worked on April 18 and April 19, 2012. On April 19, 2012, Mr. Livingston was assigned to Nurse Gabrielle as one of her patients. She stated that she saw Mr. Livingston shortly before 6:00 p.m. on the 19th to administer his medication and take his blood pressure and vital signs. She stated that she saw Mr. Livingston after dinner and recalled that he was planning on getting his hair cut on the following Monday.

[66] Ms. Gabrielle recalled that Mr. Livingston expressed an interest in western books and she made a point of noting this on the communication log in case other staff wanted to bring in books for him. Nurse Gabrielle stated that Mr. Livingston told her

he was planning on watching television during the evening. According to Ms. Gabrielle's statement, Mr. Livingston was pleasant and future orientated. Ms. Gabrielle was returning from her break when the code blue sounded and she attended to his room to see him on the floor. She stated that resuscitation efforts were made without success.

VIII. SUMMARY AND CONCLUSIONS

[67] It is clear that Mr. James Livingston died by suicide on April 19, 2012 at the Health Sciences Center in The City of Winnipeg. His death occurred by him placing a belt around his neck, looping same over the door frame in his bedroom, closing the door and then proceeding to climb up and jump off the garbage can in his room. Mr. Livingston was located almost immediately after this event but despite attempts through the use of CPR to revive him, he passed away.

[68] It is also clear that four days before his death, on Sunday, April 15, 2012, Mr. Livingston had been found with his belt draped loosely around his neck. This event occurred at about the time Mr. Livingston had been directed to wash the clothes that he had been wearing that were terribly soiled. At the time Mr. Livingston was found with the belt, he expressed no desire to harm himself.

[69] Nurse Phil Kwan made a notation in the progress notes concerning the incident involving Mr. Livingston and also noted that his observation status was to be changed from normal to close observation. The belt incident did occur at shift change and for whatever reason, Mr. Livingston's observation status was not changed to close observation on the remainder of the documents used on ward PX2.

[70] It is also clear that this incident was not discussed at the Kardex meeting which occurred the following day, Monday, April 16, 2012. In addition, Dr. Hynes, who was Mr. Livingston's treating psychiatrist did not see Nurse Kwan's notation in the progress reports.

[71] With the exception of the April 15, 2012 incident, Mr. Livingston gave no indication that he wanted or intended to harm himself in any way. In fact, through discussions with Mr. Livingston, all staff, including Dr. Hynes, felt that Mr. Livingston was forward or future looking in terms of his attitude. Even the psychological reports prepared only a few days before his death do not mention any potential thoughts of suicide on Mr. Livingston's part.

[72] It is unfortunate that Mr. Livingston's observation status from normal to close observation was not implemented following the April 15th incident. However, from all of the evidence I have heard and read, I am satisfied that given his overall behaviour, Mr. Livingston's observation status would have reverted back to normal within 48 hours or well before his unfortunate suicide.

[73] Counsel to this inquiry has put forth two specific recommendations for the Court's consideration. I have considered these recommendations in light of all the evidence I have heard and I concur that these should form part of the Court's conclusions for this inquest.

IX. RECOMMENDATIONS:

<u>Recommendation #1</u>:

[74] That the Winnipeg Regional Health Authority implement a policy in writing that the observation level of each patient on the PX2 ward of Health Sciences Centre's Psych Health Unit is to be recorded in a manner easily and continuously accessible to all staff. Prior to the conclusion of each shift, the designated "charge nurse" is tasked with the responsibility of ensuring the observation level of each patient is accurately recorded in whatever method is utilized that is easily and continuously accessible to all staff.

<u>Recommendation #2</u>:

[75] At each "Kardex meeting", attendees are to be informed of the names of all patients who have had their observation level changed by any nurse or doctor since the last Kardex meeting was held, regardless of how long the change was in effect for or whether it is still in effect at the time of the meeting.

Dated at the City of Winnipeg, in Manitoba, this 23rd day of June, 2015.

Original signed by:

Robin Finlayson.
Provincial Court Judge