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March 20, 2019

The Honourable Margaret Wiebe
Chief Judge
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

Inquest into the death of Frank Alexander
Our file: 2015-0158

Dear Chief Judge Wiebe:

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendations into the March 28, 2011 death of Frank Alexander. The May 26, 2015 inquest report of the Honourable Judge Michel Chartier was publicly released on May 29, 2015.

BACKGROUND

Based on the inquest report of Judge Chartier, staff of Parkview Place, a personal care home (PCH) in Winnipeg, found Mr. Frank Alexander (a resident) on the floor of the PCH on March 24, 2011, at about 7.00 p.m. Mr. Alexander was bleeding from his left ear and there was blood on the floor under his head. Another resident had apparently assaulted him. Staff of the PCH called the Winnipeg Fire Paramedic Service, and nursing staff attended to him until emergency personnel arrived.

Emergency personnel then took Mr. Alexander to the Emergency Department, Health Sciences Centre, where he was diagnosed with a traumatic brain injury. The diagnosis was discussed with his 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 Health Centre, where he died of blunt head trauma. Mr. Alexander had a past medical history of Alzheimer's disease.

The Winnipeg Police Service was notified of the alleged assault on Mr. Alexander, and they investigated the incident. The WPS found that Joseph McLeod, a 70-year-old resident of the PCH, who also had Alzheimer's disease, had pushed Mr. Alexander, causing him to fall on his

head. Accordingly, the WPS arrested Mr. McLeod and charged him with aggravated assault, which was later upgraded to manslaughter. Mr. McLeod was found unfit for trial. He was transferred to a locked ward at the Selkirk Mental Health Centre and has since passed.

RESPONSE TO INQUEST RECOMMENDATIONS

The Honourable Judge Michel Chartier made 10 recommendations, which Manitoba Health, Seniors and Active Living (MHSAL or the department) addressed as 23 recommendations and 26 Action Statements.

In MHSAL's letter dated June 6, 2018, with which they included a document detailing the 23 recommendations and linking them to the corresponding 26 Action Statements, the department advised that 24 of the 26 Action Statements were complete. The department stated that the two remaining Action Statements do not require any further review or work. Details of the department's action(s) on these two Action Statements will be provided later in this report.

In reviewing the department's detailed response, we observed that it was missing reference to two recommendations, namely recommendations #7 and #13. We enquired from MHSAL about the omission, and on March 18, 2019, the department provided clarification to the effect that the two recommendations had been addressed through the Recommendation Implementation Team's efforts with the health system.

The department further stated *"Recommendation #7 from Line 261 in the Report states, "There is a definite need for better communications amongst all of the stakeholders". In the Implementation Team Plan, it states that "The team will provide leadership on the implementation of these action statements in all regions to the fullest extent possible. Strengthened communications will be incorporated into the implementation of all action statements." Therefore, no separate action statements were identified, but rather communication was an area addressed throughout the work to address all action statements, evidenced by having a multi-stakeholder Implementation Team, processes established with the Department of Justice and resource materials distributed across all Personal Care Homes in the system.*

Recommendation #13 from Line 271 in the Report states, "Training in this regard for all staff must be mandatory" and is specifically speaking to the need for mandatory training for all staff on residents with aggressive/responsive behaviours. This recommendation has been addressed through the process of now having this training incorporated into the PCH Standards and assessed at each Standards Review which is covered in Recommendation #14, and was one of the first Recommendations to be addressed".

Judge Chartier indicated in his report that many of his recommendations were inextricably related and that it would likely be impossible to implement certain recommendations without first implementing others. Consequently, in MHSAL's response, many of the Action Statements applied to more than one recommendation. In reproducing the recommendations and Action Statements, the statements that apply to more than one recommendation are written in light blue, when repeated.

The numbering style adopted by MHSAL for the 26 Action Statements starts with FAI-01 and culminates at FAI-18. In between, FAI-10 is further subdivided as FAI-10a to 10g and FAI-16 is subdivided into FAI-16a to 16c, to account for the 26 Action Statements.

The recommendations and MHSAL's response on how they have attended to them are discussed in the ensuing paragraphs.

Recommendation #1

The focus of these events[1] and the resulting recommendations revolve around the City of Winnipeg. These recommendations, however, are in large part applicable province wide.

Action Statements

FAI-01: The department has incorporated Alzheimer and related dementia training in personal care home standards measures and will monitor compliance during standards reviews.

FAI-02: The department and regions have established standardized definitions for specialized environments in personal care homes.

Recommendation #2

There must be a substantial increase in the number of beds dedicated to people with violent or aggressive tendencies.

Action Statements

FAI-08: The department will study the feasibility of creating specialized environments for residents with dementia, in each personal care home, in the province.

FAI-09: The department and the regions will analyze current and future needs for specialized environments annually, and incorporate this analysis in the planning for any renewal or new construction of personal care homes.

FAI-10a: The regions will track the use, demand and wait time for specialized environments, and report to the department on a monthly basis.

FAI-11: The department and regions will study the feasibility of a target that clients should wait no longer than 60 days for placement in specialized environments.

[1] i.e. the events concerning the death of Mr. Alexander – who had Alzheimer's disease – which was caused by aggravated assault on him by another resident suffering from the same disease, in a PCH.

Recommendation #3

The Winnipeg Regional Health Authority (WRHA) and the department of Health increase the number of behavioural units, in order to ensure that the maximum wait for such a bed be no more than 60 days.

Action Statements

FAI-02: The department and regions have established standardized definitions for specialized environments in personal care homes. (repeated)

FAI-11: The department and regions will study the feasibility of a target that clients should wait no longer than 60 days for placement in specialized environments. (repeated)

Recommendation #4

Creative solutions must be found, to accommodate persons with violent/ aggressive tendencies. 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.

Action Statements

FAI-03: The team will develop alternate support protocols to be used if demand is greater than capacity as the system develops specialized environment infrastructure. Also, the alternate support protocols are to be used in locations across the province, where staff recruitment may be a challenge to operate a specialized environment.

FAI-04: The team will develop alternate support protocols to manage aggressive and violent behaviours for residents/ clients awaiting placement in a specialized environment.

FAI-05: Regions will develop a protocol for tracking/ reporting aggressive incidents in personal care homes.

FAI-06: Regions will develop protocols/ policies to support staff reporting dangerous situations in facilities.

FAI-07: The team will develop a protocol to determine when residents/ clients are to be placed in a specialized environment, when residents/ clients will require a locked unit, and when a physician/ psychiatrist is to be consulted. The protocol will outline a process to alert staff when a resident has had an aggressive incident or is refusing medications.

FAI-08: The department will study the feasibility of creating specialized environments for residents with dementia, in each personal care home, in the province. (repeated)

FAI-10b: The regions will implement alternative support protocols to manage aggressive and violent behaviors within facilities while residents wait for specialized environment placement.

FAI-10d: The regions will develop and implement a protocol that outlines how personal care homes apply for funding for residents with aggressive/ violent incidents. This protocol/ policy will provide increased guidance to help facilities manage these residents, while confirming all other options of behavioral interventions have been exhausted.

Recommendation #5

The Court recommends that the WRHA and the Department of Health be directed to work with all Personal Care Homes (PCHs) to create a unit within each PCH to address the needs associated with persons exhibiting violent and aggressive behavior.

Action Statements

FAI-08: The department will study the feasibility of creating specialized environments for residents with dementia, in each personal care home, in the province. (repeated)

FAI-09: The department and the regions will analyze current and future needs for specialized environments annually, and incorporate this analysis in the planning for any renewal or new construction of personal care homes.

FAI-10a: The regions will track the use, demand and wait time for specialized environments, and report to the department on a monthly basis. (repeated)

Recommendation #6

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.

Action Statements

FAI-12: The regions will determine a process incorporating a three-month follow up for client situations where home care services/ assessment has been refused and the client has dementia.

FAI-13: Regions will develop a process/ system to track client situations requiring three-month follow up.

Recommendation #8

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.

Action Statements

FAI-12: The regions will determine a process incorporating a three-month follow up for client situations where home care services/ assessment has been refused and the client has dementia. (repeated)

FAI-13: Regions will develop a process/ system to track client situations requiring three-month follow up. (repeated)

Recommendation #9

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.

Action Statements

FAI-15: The team will establish a sub-group with representatives from the department, the regions and Manitoba Justice to develop a protocol to outline supports for long-term care residents/ home care clients with dementia who are charged with a criminal offense.

FAI-16a: The protocol will address assessments for individuals and considerations for accommodating the healthcare and justice requirements.

Recommendation #10

The protocol should require that any assessment undertaken for the healthcare system include a review of the records from the Winnipeg Remand Centre (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.

Action Statements

FAI-16b: The protocol will address assessment requirements for the full details of the events before incarceration as well as events that have occurred since incarceration.

FAI-16c: The protocol will address the sharing of custodial records, health records and crime reports.

Recommendation #11

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.

Action Statements

FAI-17: To develop the protocol, the sub-group of the team will seek privacy and legal expertise and consult with law enforcement agencies to discuss dementia education for front-line officers.

Recommendation #12

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 Transition Advisory Panel (TAP). 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.

Action Statements

FAI-10e: The regions will establish a specialized panel process to provide placement advice for residents/ clients with known aggressive/ violent tendencies.

Recommendation #14

The Court recommends that PCHs be mandated to increase the scope of training for all staff who interact 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 the Physical, Intellectual, Emotional, Capabilities, Environment, and Social program (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. Education in this regard for all staff must also be mandatory.

Action Statements

FAI-01: The department has incorporated Alzheimer and related dementia training in personal care home standards measures and will monitor compliance during standards reviews. (repeated)

FAI-10g: The regions will work with personal care homes to implement dementia training for all staff.

Recommendation #15

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.**

Action Statements

FAI-07: The team will develop a protocol to determine when residents/ clients are to be placed in a specialized environment, when residents/ clients will require a locked unit, and when a physician/ psychiatrist is to be consulted. The protocol will outline a process to alert staff when a resident has had an aggressive incident or is refusing medications. (repeated)

Recommendation #16

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:

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

Action Statements

FAI-05: Regions will develop a protocol for tracking/ reporting aggressive incidents in personal care homes. (repeated)

FAI-07: The team will develop a protocol to determine when residents/ clients are to be placed in a specialized environment, when residents/ clients will require a locked unit, and when a physician/ psychiatrist is to be consulted. The protocol will outline a process to alert staff when a resident has had an aggressive incident or is refusing medications. (repeated)

FAI-08: The department will study the feasibility of creating specialized environments for residents with dementia, in each personal care home, in the province. (repeated)

FAI-10c: The regions will implement policies requiring personal care homes to review placement options for a resident following an aggressive/ violent incident in their facility. This policy will also outline the reassessment process in the region.

Recommendation #17

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.

Action Statements

FAI-10f: The regions will assess the feasibility of conducting specialized panels twice per month.

Recommendation #18

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.

Action Statements

FAI-10d: The regions will develop and implement a protocol that outlines how personal care homes apply for funding for residents with aggressive/ violent incidents. This protocol/ policy will provide increased guidance to help facilities manage these residents, while confirming all other options of behavioral interventions have been exhausted. (repeated)

Recommendation #19

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.

Action Statements

FAI-04: The team will develop alternate support protocols to manage aggressive and violent behaviours for residents/ clients awaiting placement in a specialized environment. (repeated)

FAI-18: Regions will institute policies that indicate all staff members have the right to call police when residents exhibit violent behaviour. This policy will include education for staff on police discretion and potential outcomes of police involvement.

Recommendation #20

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.

Action Statements

FAI-10c: The regions will implement policies requiring personal care homes to review placement options for a resident following an aggressive/ violent incident in their facility. This policy will also outline the reassessment process in the region.

Recommendation #21

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.

Action Statements

FAI-04: The team will develop alternate support protocols to manage aggressive and violent behaviours for residents/ clients awaiting placement in a specialized environment. (repeated)

FAI-05: Regions will develop a protocol for tracking/ reporting aggressive incidents in personal care homes. (repeated)

FAI-06: Regions will develop protocols/ policies to support staff reporting dangerous situations in facilities. (repeated)

Recommendation #22

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.

Action Statements

FAI-14: A plan will be developed by the department and regions to improve public awareness about life in personal care homes.

Recommendation #23

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.

Action Statements

FAI-17: To develop the protocol, the sub-group of the team will seek privacy and legal expertise and consult with law enforcement agencies to discuss dementia education for front-line officers. (repeated)

FAI-18: Regions will institute policies that indicate all staff members have the right to call police when residents exhibit violent behaviour. This policy will include education for staff on police discretion and potential outcomes of police involvement. (repeated)

As stated previously at page 2, in MHSAL's letter of June 6, 2018, they indicated that two Action Statements do not require any further work, and these are FAI-11 and FAI-14.

MHSAL advised, with regard to FAI-11, that they determined the best course of action was to identify areas with the most need for specialized environment, using analysis of data from the new long-term care dashboard tracking. MHSAL stated that "tracking of this data began in April 2017 with the RHAs submitting quarterly information to the department. The department will monitor this data and use it to inform planning in the system regarding this type of capacity in our Personal Care Homes".

With regard to FAI-14, MHSAL stated, "the Frank Alexander recommendation implementation team concluded that a public awareness campaign across Manitoba is not necessary or beneficial. An alternative solution of enhancing the information found on the regional health authorities' (RHAs) websites was proposed. The Long Term Care Association of Manitoba has a Frequently Asked Questions section on their website and have authorized the department and RHAs to link to it, if they wish. The alternate solution was accepted and there is no further planned work on this action statement".

MHSAL advised that the final meeting of the Frank Alexander recommendation implementation team occurred in March 2018, where it was determined that no further meetings were required. This decision was made considering the progress made on the Action Statements.

With regard to Recommendation #23 (which was a suggestion by Judge Chartier), we recently made enquiries as to the status of the matter from Owen Fergusson, the acting executive director of Policing Services and Public Safety, Manitoba Justice. Mr. Fergusson advised that a Manitoba Police Information Note (MPIN), advising about the recommendation, was distributed to all police agencies in Manitoba on January 30, 2019. This action aligns with our prior understanding with Manitoba Justice, to distribute an MPIN to all police agencies when a recommendation or suggestion is directed to police services generally, as was the case in this inquest.

CONCLUSION

As MHSAL has provided a full response to the inquest recommendations, we will conclude our monitoring of the implementation of the recommendations. Please note an electronic copy of this report will be posted on the Manitoba Ombudsman website: www.ombudsman.mb.ca.

Yours truly,

Marc Cormier
Acting Manitoba Ombudsman

cc: Ms. Karen Herd, Deputy Minister, Manitoba Health, Seniors and Active Living (MHSAL)
Lorraine Dacombe Dewar, Executive Director, Mental Health and Addictions, Primary Health Care and Seniors Continuing Care, MHSAL
Mr. Dave Wright, Deputy Attorney General and Deputy Minister, Manitoba Justice
Dr. John K. Younes, Chief Medical Examiner