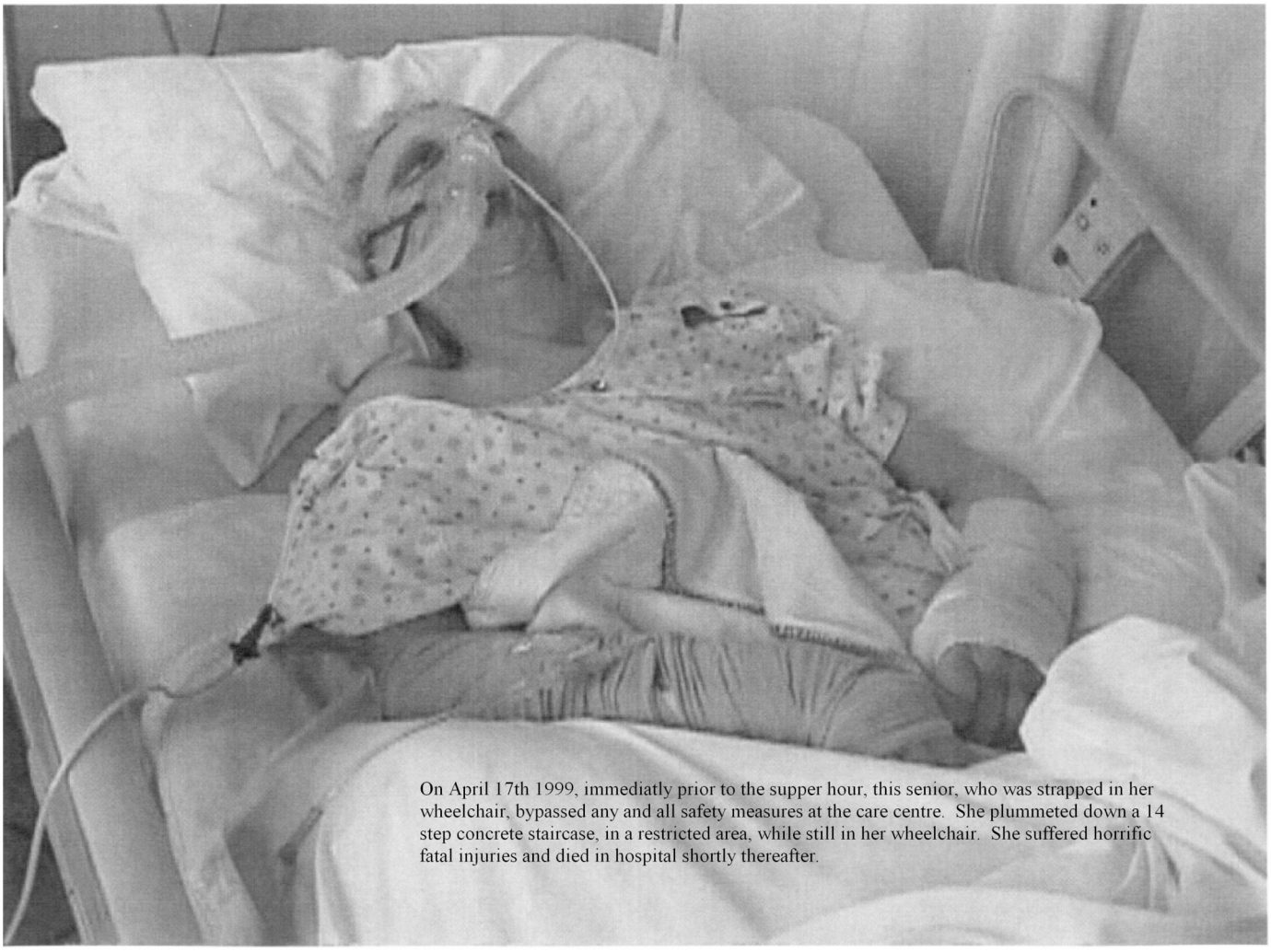
FATAL NEGLECT
AT THE MAYFAIR

File:03A



"On April 17th, 1999 immediately prior to the supper hour, this senior, who was strapped in her wheelchair, bypassed any and all safety measures at the care centre. She plummeted down a 14 step concrete staircase, in a restricted area, while still in her wheelchair. She suffered horrific fatal injuries and died in hospital shortly thereafter."

ALBERTA
HEALTH

Office of the Minister

JUL 0 8 1999

Mr.
14515 – 19 Street NW
Edmonton, Alberta
T5Y 1S6

Dear ,

In accordance with Section 8(6) of the *Protection for Persons in Care Act* (the Act), I am providing you with the decision taken, as attached, following the investigation into your April 17, 1999 report of failure to provide the necessities of life, under the Act. Please accept condolences on the passing of your wife's aunt.

Thank you for your report under the *Protection for Persons in Care Act*. It is the intent of the Act to better protect the health, safety and well-being of adults in care.

Yours sincerely,

Halvar C. Jonson
Minister

Attachment
File #: 99110-05

1999
towards a society for all ages
International Year of Older Persons 1999

228 Legislature Building, Edmonton, Alberta, Canada T5K 2B6 Telephone 780/427-3665 Fax 780/415-0961

PROTECTION FOR PERSONS IN CARE

Report of a Decision of the Minister Respecting Complaint #99110-05

The disposition of the matter as recommended by the Investigator appointed is approved. Following an investigation and discussion with affected parties, the Investigator advises:

- That the complaint of abuse by failing to provide the basic necessities of life be dismissed as there is insufficient evidence of intent to cause harm.

- That a finding be made that the facility failed in its duty under the Protection for Persons in Care Act to "maintain a reasonable level of safety for its clients."

The Investigator recommends that the following measures be implemented to enhance resident safety in the facility:

- That an assessment be completed by a safety expert to determine a means of restricting resident access to the laundry and kitchen areas and exits. This expert should be asked to recommend a solution that takes into consideration such things as fire regulations, reasonable access by staff and resident safety.
- That the recommendations of the safety expert be implemented within a reasonable time following completion of the expert's report.
- That guidelines be developed and implemented for consistent completion and routing of Incident and Hazard Reports.
- That a mechanism for tracking safety or hazard trends be designed and implemented. This system should be impervious to staff turnover and variances in personal memory.
- That management report back on their action to a staff member who reports a hazard or safety risk. Further, that management follow-up to ensure the effectiveness of solutions that have been implemented as a result of a hazard or incident report.
- That all staff be requested to review their personal understanding of and commitment to using safety devices and processes at the facility. This means that:
    - all staff commit to "rescue" any resident who has wandered to a place that the resident should not be.
    - all staff commit to not prop doors open that have a safety reason to be closed.

.../2

- all staff commit to report to nursing staff if a resident has wandered where the resident should not be.
- all staff commit to enter and exit the facility through approved routes only.
- all staff commit to ensure that all locking or closure devices are used appropriately.
- all staff commit to report any hazard or safety problem and request to be advised of the outcome of their report.

The Investigator further recommends that the facility revises its Policies on Abuse to reflect that all employees have an equal legal responsibility to report alleged abuse under the Protection for Persons in Care Act. Further, the Policy could state that employees are encouraged to report alleged abuse to their supervisor to assist the employer in complying with the Act.

Date: June 24, 1999

FAXED 10/5/99

May 10, 1999

Dr. Pauline Alakija
Medical Examiner
4070 Bowness Road NW
Calgary, Alberta T3B 3R7

Re: **Death of Miss**

Request for Public Inquiry

Dear Dr. Alakija:

I am writing to you regarding the circumstances surrounding the death of Miss Calgary, who died on April 19, 1999, of injuries sustained at the Mayfair Care Centre, 8240 Collicut Street SW, Calgary on April 17, 1999.

My wife, Shirley, and I were Guardians and Trustees fc who was my wife's Aunt, and we are also the Executors of her estate. In those capacities, we have looked after her since November 12th, 1996, when we were granted Guardianship due to her displaying symptoms of dementia.

Mary was a resident at Mayfair since March 1997. During that time she had at least four and maybe five falls serious enough for the staff to telephone us about. The last two resulted in fractures: a fractured arm in July, 1998; and a fractured right femur in January 1999, resulting in a half-hip replacement. I realize that latent independence and wandering habits were probably factors in both accidents, and probably her last (fatal) one. I do feel very strongly that the Care Centre should have had safety protocols in place commensurate with the geriatric level of the residents.

As your report will, I am sure, point out, suffered from multiple blunt injuries and countless contusions and abrasions, an indignant and horrible fate that no-one should ever have to suffer. These injuries may have been due in part to negligence by Mayfair Care Centre. It is my wife's and my only wish that that this fate not befall any other resident of this or any seniors' facility in Alberta.

Having visited the site of incident on the day following, we saw that the heavy wood doors between the dining-room and laundry were bolted shut at the top. We also noted that the door from the laundry to the landing at the top of the stairs where fell was closed by a heavy-duty closing apparatus, which I had trouble opening. We could only assume that this door had been propped or held open at the time of the accident, and we have a witness who saw both sets of doors left open on the Sunday morning following the accident. The bolts on the wood doors could only be reached by a person of a height of about 5'8" or so – I am 5'9 1/2" and had to stretch to reach them . Most of the Mayfair staff would have to use a chair or step device to reach these, and may be the reason that neither my wife nor I never once saw these doors closed, much less locked, in the whole time we had

visitec at Mayfair. On almost every visit, one of us would have to check for lost articles of Mary's clothes.

The staff at Mayfair have not contacted us to explain what happened in any detail. I can understand their concern over liability. I feel that any negligence was caused by problems in the infrastructure that could have been foreseen by management, but which might have cost money. An example of this would be to have put a "Wander-Guard" detector on the doors into the laundry room or have had an electronic lock installed. Similarly, both outside doors at the rear of the building should have had detectors on them as well, as , had gotten out through the Kitchen door during the Winter of '97/'98, during a bitterly cold spell. I saw, during a visit on April 29th, 1999, that Mayfair have installed a gate across the offending staircase, a little like "closing the gate after the cows have escaped". We have been told that the owners of the Mayfair Care Centre also own the Glamorgan Care Centre, and that the Mayfair is the better of the two. I can only pity the residents at Glamorgan.

For these reasons, my wife and I feel strongly that this incident requires a Public Inquiry, to ensure that the proper steps are taken to:

a. Determine the cause of the incident which caused death;

b. To ensure the safety of the residents at Mayfair Care Centre; and

c. To ensure that this type of accident does not recur in Alberta.

If further information is required, I can be reached at:

Telephone (Bus): (780)
Fax (Bus): (780)
Telephone (Res): (780)4

Respectfully,

Guardians, Trustees and Executors for
The late