



**Report to the Minister of Justice
and Attorney General
Public Fatality Inquiry**

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the _____ Law Courts
in the _____ City _____ of _____ Edmonton _____, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the _____ 12th _____ day of _____ February _____, _____ 2009 _____, (and by adjournment
year
on the _____ 13th _____ day of _____ February _____, _____ 2009 _____),
year
before _____ James K. Wheatley _____, a Provincial Court Judge,
into the death of _____ James Rudolph Rolheiser _____ 52 _____
(Name in Full) (Age)
of _____ #201, 10920 – 83 Street Edmonton, Alberta _____ and the following findings were made:
(Residence)

Date and Time of Death: _____ Undeterminable _____

Place: _____ Edmonton, Alberta _____

Medical Cause of Death:

Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquires Act, Section 1(d)).

Undetermined

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Undetermined

Circumstances under which Death occurred:

The deceased contacted his sister on the morning of March 16, 2006. He complained of not being well and asked for her help in going to hospital. His sister Janice MacDougall was concerned as a result of the tone of his voice and decided to take the day off from her occupation to help him. She had to wait until her son was home from school and then went and picked up her brother to take him to an emergency ward. In her evidence she says that she was immediately concerned as her brother was white, very obviously out of character, and flat toned in his presentation and manner.

They attended at the emergency ward at the Grey Nuns Hospital in Edmonton where they were confronted with a medical sign which indicated that no mental health services were available. They confirmed this with the triage nurse on duty who advised them that they would need to go to another hospital. They were not directed to another hospital in particular.

The first choice of hospitals was made as being close to the sister's home so that if Mr. Rolheiser was to be hospitalized he would be close to his sister's address. The second choice of hospitals, being the Royal Alexandra, was selected so that it would be close to Mr. Rolheiser's home.

Ms MacDougall tells us that they arrived at the Royal Alexandra, checked in, and were asked to wait. Records provided to the inquiry indicate that the medical triage nurse saw them at 16:43 (4:43 p.m.) and requested the mental health triage nurse to see Mr. Rolheiser at 16:50. The mental health triage nurse in her evidence indicated that she would have come almost immediately.

The sister Ms. MacDougall advises the inquiry in her evidence that when her brother went with the triage nurse, her son left to go to a convection vending machine where he obtained a bag of potato chips. He returned to the emergency ward, got out his homework and started work on it and at that point Mr. Rolheiser exited the triage area and provided his sister with information by way of a printed form that he had been referred to outpatient care the following week. Mr. Rolheiser's sister Ms. MacDougall advises that although she had made her presence aware to hospital, she was not spoken to by anyone. Ms. MacDougall indicates in her evidence that the time her brother was gone for triage was more than half an hour but less than an hour. Ms. MacDougall advises that her brother was on some medication for his prostate and had not eaten that day and she took him for dinner at Wendy's where they arrived at approximately 6:00 p.m. and were at Wendy's until approximately 6:30, some thirty minutes to allow for a period of thirty minutes after eating before Mr. Rolheiser took his prostate pills. From there they returned to Mr. Rolheiser's home where they watched the hockey game. She comments that his mood was very flat and that although they watched the hockey game, and that he is a great hockey fan, he was not enthusiastic in his normal fashion. She advises that he made a telephone call to the crisis line regarding his state, such call being made as a result of information that he had received at the hospital. Ms. MacDougall advises that as a result of information they got from a Bruce on the crisis line, she actually did a count of her brother's medications. Ms. MacDougall and her son stayed with the deceased until 9:30 when they went home, having received assurances from him that he was going to be going to bed. She telephoned him at 10:30 that night, confirmed that he was in bed, and that he had taken his sleeping pills. She advised her brother that she would be contacting him the next morning to see how he was doing.

Ms. MacDougall telephoned him the next morning, could get no answer, but left it for awhile as she advised that he brother normally goes for walks but she was not able to contact him and as a result of that, contacted the landlord of her brother's building together with a neighbor and was able to gain entry to her brother's apartment. He was not there, the place was clean but there was indication that he had in fact laid on his bed by virtue of indentation on the bed clothes. She

checked his medications and all that were missing were two prostate pills and four sleeping pills which she assumes that he would have taken during the evening. All other medications were there as was his identification.

Ms MacDougall and the neighbor Liz Falls instituted a drive around search during the afternoon trying to locate her brother but with increasing anxiety were unable to affect any trace of him. They returned to his apartment and the neighbor Ms. Falls contacted police. Police attended fairly promptly and missing person reports were filed and the neighbor Ms. Falls advised the police that she had heard Mr. Rolheiser talking about potential suicide and going down into the river valley to affect such actions. Reports were filed with the police but no searches were undertaken by the police.

Ms. MacDougall over the next number of days instituted civilian searches of the river valley area and posted missing person signs throughout the city and as far away as Wetaskiwin. These efforts resulted in nothing until a home less person wandering in the river valley notified police that he had found human remains on August 28, 2006. Police attended initially and found some parts of a body but were restricted by darkness. The next day a more thorough search of the area was made and the majority of forms of skeletal remains were in fact located.

Ms. MacDougall heard of this finding on a media outlet, contacted the police and she was asked details of what he was wearing, in the way of clothing, and the police confirmed later in the day that the remains found were probably her brother.

The medical examiners officer and archeological consultants from the University of Alberta examined the skeletal remains and having accessed information in respect of clothing worn at the time of disappearance, dental x-rays and other x-rays were able to establish that in fact the remains were Mr. Rolheiser and this was confirmed to Ms. MacDougall on September 5th.

As most of his remains were gone with the exception of bones, which showed some carnivore chewing, no toxicology was able to be done and the Medical Examiner's Office was unable to indicate a cause of death.

The remains were found in a wooded area of the river valley virtually across the street from Mr. Rolheiser's residence. The foregoing are the circumstances as formed from the evidence of Ms. MacDougall.

Staff Sergeant Bill Spinks gave evidence at the Inquiry. His review of the police records indicated to him that no search was undertaken by police. He indicated that he was put in charge of putting together a missing persons protocol but this was after the dates of this particular incident. His evidence was that virtually no protocol, in an aggressive sense of search, was in place at the time of Mr. Rolheiser's disappearance and that any action on the missing persons report, of an aggressive nature, really at that time would be on the basis of any officers that were involved taking it upon themselves rather than in the form of a planned missing persons procedure. Staff Sergeant Spinks advises and was able to provide the Inquiry with new policies that he developed and have been put in place where there is a central accumulation of all missing person information and that various steps are put in place and planned whereby the police will in fact institute prompt search procedures and public notification procedures in the event of a person going missing. There are as well personnel now charged with risk evaluation in respect of individual circumstances of missing persons so that, especially in mental health and health areas, stepped up procedures can in fact take place. He advised that under the new and current policy a dog unit, an air unit, and a ground search with search manager would be mobilized.

Dr. Patrick White, who is the Regional Clinic Program Director of Psychiatry for the Capital Health Board, gave evidence in respect of the establishment within each hospital in the province of a

mental health team which would be put in place upon identification of a mental health issue to provide specific mental health services upon the attendance at any emergency ward of a person with mental health difficulties. This is an established protocol where specially trained triage units deal with such people presenting in emergency wards and have the ability to call upon resident and staff psychiatrists as the occasion would require. The basic procedure is as follows:

1. Medical triage which may identify mental health issues.
2. Mental health triage which would identify mental health issues.
3. Medical emergency doctor follow up with mental health triage to determine a course of action.
4. Referral to outpatient care or admission.

Upon being advised of the sign which was found at the Grey Nun's Hospital by Ms. MacDougall and Mr. Rolheiser, Dr. White advised that this was contrary to policies in the hospitals but that he had in fact heard of it happening once before and had in fact required that such sign be removed. His view was that mental health triage together with resident psychiatrist and staff psychiatrist services were available at all Edmonton hospitals on a twenty-four hour basis. He could offer no explanation as to what took place at the Grey Nuns Hospital.

Nurse Cheryl Lemay, the Emergency Mental Health Response Team member, gave evidence that upon being paged she attended and interviewed Mr. Rolheiser and prepared various notes which ultimately became a copy of the report filed with the Inquiry. She had, she stated, no independent recollection of Mr. Rolheiser other than that which emerged from her refreshing her memory by virtue of the report. She said that her interview and time with Mr. Rolheiser would have taken at least an hour whereupon she would have gone and found Dr. Sosnowski, the emergency doctor assigned, briefed him, and left it to him to view her recommendations and make his final disposition.

Nurse Lemay indicated in her report that Mr. Rolheiser had been somewhat adamant about being admitted but that her determination was that his suicidal risk was low and that a better treatment of him would be by virtue of him being referred to outpatient care the following Monday.

Nurse Lemay advised that she was confronted by Ms. MacDougall in respect of the non-admission of her brother and that she had advised Ms. MacDougall to speak to Dr. Sosnowski about this. Nurse Lemay also confirms that she advised Dr. Sosnowski of this conversation with Ms. MacDougall.

Nurse Lemay indicated that she had had a discussion with Ms. MacDougall, Mr. Rolheiser's sister, where Ms. MacDougall was adamant about her brother's admission and that Nurse Lemay had indicated that Ms. MacDougall should speak to Dr. Sosnowski about this. Nurse Lemay indicates that she had advised Dr. Sosnowski of this. Dr. Sosnowski gave evidence. He acknowledged his assignment to the case, the fact of having been briefed by nurse Lemay, which he said normally takes ten to fifteen minutes, being provided with copies of her notes and then meeting with Mr. Rolheiser. He stated that although he has no records to indicate when he saw Mr. Rolheiser or for how long he saw Mr. Rolheiser, that such attendance would have been in the norm fifteen to thirty minutes. Dr. Sosnowski did not feel that Mr. Rolheiser was at risk and concurred with the nurse's recommendations. Mr. Rolheiser was provided with a form directing him to outpatient care and was discharged. Dr. Sosnowski did not feel that Mr. Rolheiser was, at this time, a danger to himself or at risk. Dr. Sosnowski found no need to consult further with a psychiatrist.

Dr. Sosnowski indicated that the referral to outpatient care was a referral by means of providing Mr. Rolheiser with access to phone numbers and location of the outpatient facility but leaving it upon Mr. Rolheiser to in fact contact them the following week. Dr. Sosnowski was not aware of any procedures whereby follow up at the instance of the outpatient clinic to a referee was in

place.

There is no indication of any medical triage ever being done. Dr. Sosnowski did not speak to Ms. MacDougall and has no memory of Nurse Lemay asking him to speak to her.

Dr. Sosnowski, in his testimony, indicated that the emergency department information system (EDIS) records times when people deal with an emergency patient. Those records were requested and when obtained provided the following information:

Emergency triage 1643 hours
Nurse Lemay signs in 1659
Nurse Lemay signs out 1830
Dr. Sosnowski signs in 1723
Dr. Sosnowski signs out 1830

No follow up to a referral for outpatient care was made at the time of Mr. Rolheiser's visit to the Royal Alexandra but we are advised that a follow up phone call was made by the medical health response team within 24 to 72 hours after they are initially seeing that patient.

Recommendations for the prevention of similar deaths:

1. Medical professionals need to review the stated policy of 24-7 availability of mental health response in all hospitals in the Capital region. If this is their policy, steps need to be taken to ensure that it is followed in all facilities.
2. Although the Edmonton Police Service policy in respect of missing persons has been substantially updated, that policy should be subject to a continuing re-evaluation to ensure that a prompt and timely response can be achieved.
3. Medical professionals should review the policy in respect of the first stage triage (medical triage) to ascertain if all persons who refer with a mental health problem should be medically assessed in respect of any possible medical collateral issues and, if this is the case, that policy should be instituted promptly.
4. Medical professionals should reassess their policy and determine if when a mental health issue is presented the decision to discharge is properly placed in the hands of an emergency room physician or a psychiatric professional.
5. A system should be instituted in emergency rooms to indicate and document, on an easily assessable basis (i.e. on the reports filed), the times of arrival of patient, when the patient is seen by medical, when the patient is seen by mental health response team, when the patient is seen by an emergency room physician, when the patient is seen by a psychiatrist and this time system should indicate the length of time that such attendance takes.
6. Notes taken by the medical health response team in respect of their interview with a patient should be maintained as chart notes and not destroyed. This should apply to any notes taken by the medical emergency doctor. Such records should be maintained for a reasonable period of time.
7. If mental health services are not available at any particular facility policy should be instituted whereby a referral to the nearest facility offering such services. Policies respecting outpatient referrals together with follow up of such referrals should be instituted on a formal basis to ensure that any crisis has past.
8. When a patient attends with mental health issues and is in the company of a family member, a policy should be instituted requiring the mental health response team and the medical doctor to speak to such family to ensure that any pertinent collateral facts are not missed or ignored.

DATED _____ March 13, 2009 _____ ,

at _____ , Alberta.

Original signed by

The Honourable J.K. Wheatley
A Judge of the Provincial Court of Alberta