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Canada's inquest system lacks teeth

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We live in an upside down world.

We can split the atom and explore space but keeping seniors in care safe continues to be a challenge.

Sprinkler rules for seniors' facilities are back on the agenda after a deadly Quebec fire earlier this year. We know that sprinklers save lives. The National Fire Protection Association in the United States says, unequivocally, that their organization has no record of a fire killing more than two people in a completely sprinkled public assembly, educational, institutional or residential building.

In the United States all federal care homes are now required to have automatic sprinklers. In Canada, only Ontario has comparable rules.

We know what to do here. We choose not to act.

Across Canada we are getting reports of fatal attacks on residents at nursing homes by other residents, usually suffering from dementia. Most of these cases are reviewed to see if they warrant an inquest or a deeper examination by a death review panel. Ontario's geriatric and long-term care review committee warned in a report in 2011 that, with our aging population, long-term care homes were becoming the new "mental health institutions."

Almost a decade ago, two residents in care in Ontario were killed by a senior who had a history of aggression and suffered from dementia. An inquest jury made 81 recommendations.

Key findings were that the province give increased priority to managing residents with cognitive impairments, that people who are at risk should not be admitted to any facility until they have been assessed and a care plan developed, and that specialized facilities for residents with behavioural problems should be developed.

Again we know what to do here and we choose not to do it.

Then there's the growing problem of seniors who simply wander away from care homes. Late last year the body of Joan Warren was found in Lynn Canyon Park after she wandered away from the Sunrise Senior Living facility in Lynn Valley.

There was a similar incident in 2009 in Alberta. A fatality inquiry recommended that the province develop a comprehensive strategy for people with dementia, that the use of GPS monitoring devices be reviewed, and when there is a marked change in a patient's health that health-care providers and family members are notified immediately.

The judge recommended that the findings of the inquiry be published by Jan. 31, 2010. The study was not published, and Alberta's provincial dementia strategy is still a work in progress.

Fatality inquiries not only help expose problems in elder care, their recommendations are a prescription for a

solution.

Why then do the findings of inquests and fatality inquires often go unheeded? One final case study gives us our answer. In 2011, in response to recommendations of a death inquest in Ontario, the Ministry of Health and Long-Term Care committed in writing to implement a drug information system to track all medications prescribed and dispensed in the province.

In 2012 the ministry quietly abandoned the idea, deeming it too costly. Nonsense! It's the practice of doing nothing that is expensive.

The problem with the inquest system in Canada is that it doesn't have any teeth. There is no requirement that the authorities accept, comply with or even review the recommendations of a public fatality report.

Other countries have national standards for death investigations and inquests. Canada should follow their lead.

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