

EL ROUBI-LOPEZ INQUEST

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On the afternoon of June 9, 2001, Piara Singh Sandhu was admitted to Casa Verde Nursing Home in Toronto. By 7:30 p.m. that night, he had bludgeoned Ezeldine El Roubi and Pedro Lopez, his two roommates to death, and attempted to kill a third resident of the home.

Mr. Sandhu was charged with the murders and sent for psychiatric assessment at Penetanguishene Mental Health Centre, where he later died without the charges having been resolved.

The deaths horrified the long-term care community. What happened to make Mr. Sandhu kill his roommates? Were there missed signs of his violent nature? Why did it happen? Could it happen again? How could we prevent another such tragedy from occurring?

On September 27, 2004, Dr. Barry McLellan, Chief Coroner for Ontario announced that there would be an inquest into the two deaths to try to find answers to some of these questions.

Concerned Friends of Citizens in Ontario Care Facilities is a non-profit, grass roots organization whose unwavering advocacy on behalf of residents in long-term care homes has resulted in many systemic changes. The Advocacy Centre for the Elderly was pleased to have the opportunity to represent Concerned Friends at the inquest.

The inquest commenced on January 31, 2005. On April 18, 2005, the jury returned with 85 recommendations¹ aimed at reforming a long-term care system unable to meet the needs of difficult residents.

An inquest is an inquiry into the death(s) of a person(s). The purpose of the inquest is twofold. First, an inquest is held to determine five questions, which are: who the deceased was; how the deceased died, when and where the deceased died; and by what means the deceased came to his or her death. Here, these questions were easily answerable and were not the ultimate goal of the inquest.

¹ A copy of the jury's recommendations can be found on the Advocacy Centre for the Elderly's website - www.advocacycentreelderly.org.

Of primary importance here was the second purpose, which is to make recommendations directed to avoiding future similar deaths. Unfortunately, while coroner's juries do make recommendations for systemic change, the recommendations are just that, with no requirements that they be implemented. Public awareness of the recommendations is therefore very important so that the public may lobby for these systemic changes.

FACTS

Mr. Sandhu was a 74 year old man of east-indian origin who spoke little English. Just prior to the incident, he was living with his wife and with his son and his family. On March 25, 2001, he suffered a stroke, was hospitalized briefly and returned home after only three days, as he was becoming increasingly disruptive and confused.

On May 30th, his wife was treated by Dr. Rahl for a black eye caused by Mr. Sandhu. The doctor advised the family to contact the police or take Mr. Sandhu to a hospital (although he could not indicate why). The son stated that this was a family matter and did not want to follow either of these suggestions.

On June 2, 2001, Mr. Sandhu was taken to see Dr. Rahl to complete an application for long-term care. Dr. Rahl found him incapable of consenting to admission to a care facility (nursing home), and completed the medical report. The report included no behavioural issues other than confusion and agitation, and there was no mention of the fact that Mrs. Sandhu had suffered a black eye at the hands of her husband. At the inquest, Dr Rahl said that he believed that the application would be reviewed by another physician prior to admission, and that Mr. Sandhu would be found to be ineligible for admission.

The Etobicoke Community Care Access Centre processed the application for long-term care. The family told the CCAC that Mr. Sandhu was demanding with family, hoarding, suspicious, paranoid, verbally and physically aggressive towards spouse and son, might use objects to hit when frustrated, and screamed and was disruptive at night. The family wished Mr. Sandhu to be placed immediately on an emergency basis. Mr. Sandhu was deemed eligible for admission and a bed was found at Casa Verde Nursing Home. A further behavioural assessment was required before he could be accepted. It is not clear who provided the information for this assessment, however, it contrasted with the information provided originally as it stated only that Mr. Sandhu could be verbally aggressive.

Mr. Sandhu was admitted to Casa Verde Nursing Home early on a Saturday afternoon. The admission note completed by the charge nurse stated that Mr.

Sandhu could be "very aggressive and violent". However, the evidence was that this information was not communicated to other staff.

The afternoon appeared uneventful. Mr. Sandhu was noted to be polite and cooperative. He ate his lunch, had a nap, and wandered around. He had the staff call his home for him and it would appear that whoever he spoke to hung up on him. After supper he was brought to his room. Around 7:30 p.m. he was apprehended by staff while attacking a resident. It was then discovered that two residents had already been killed. A police officer described the scene as one of the worst homicides he had ever investigated.

RECOMMENDATIONS

Much of the evidence at the inquest was with respect to the assessment of and provision of care for potentially aggressive residents in long-term care homes.

Dr. Heather MacDonald, who had prepared the coroner's report, and Dr. Ken LeClair, a leading geriatric psychiatrist, both testified that Mr. Sandhu's potential for violent behaviour was predictable. Unfortunately, evidence showed that no proper assessment took place. Nevertheless, the jury heard that even if it had been identified, there were very few alternatives for Mr. Sandhu and his family with respect to providing him with care and treatment.

PIECES Training

The jury heard a great deal of testimony about "PIECES" training. PIECES was part of the Government of Ontario's Alzheimer's Strategy, aimed at enabling long-term care staff to assess residents for behavioural and psychiatric issues, and to problem solve regarding these issues within the home. While training was heralded, the jury heard that the funding for the training had concluded. As well, many of the PIECES trained staff had left their jobs, leaving great gaps in the system. Finally, even where PIECES trained staff were available, there was often insufficient time and support to implement their knowledge.

The jury heard that Mr. Sandhu's potential for violence could have been assessed at admission, flagging his behaviours and allowing for monitoring pending further assessment and programming. However, this was not done.

The jury recommended that funding for PIECES training continue and that there be requirements for PIECES trained staff to be available in all long-term care homes. (Recommendations 40-49)

Specialized Units and Services

Even if Mr. Sandhu had been clearly identified as being violent, it is unclear what services might have been available to assist the home in dealing with him.

The evidence was that there were few resources available for violent or aggressive residents. Special programmes were either extremely limited or not known to facility and CCAC staff. Over and over, we heard that specialized units or facilities were required for these residents, but they were generally non-existent. Tim Burns, the Director of Long-Term Care at the Ministry of Health and Long-Term Care stated that it was up to the individual long-term care homes to assess and determine proper spending on these types of residents. We heard about the requirements of high staff to resident ratios in specialized units/facilities to be able to meet the needs of these residents and it was clear the specialized services required by these residents could not be provided based upon the present funding scheme, and that increased funding had to be made available for these difficult to care for residents. (Recommendations 22-25; 38-39)

FUNDING

The present funding system for long-term care is known as the "Alberta Resident Classification System", which has been criticized by those who have looked at it and most recently, by Monique Smith, in her report to the Minister of Health and Long-Term Care, who stated that the system was problematic and recommended a review with goal to establish a new model.²

The jury recommended that the system be revised within the next fiscal year, and specifically stated that any new funding model must "take into account the higher skill level of staff required for residents with dementia [sic] and other mental health problems and, in particular, giving sufficient weight to actual and potential aggressive behaviours to ensure adequate staffing, sufficient time and resources for LTC facilities if they are responsible to manage residents with such behaviours". (Recommendation 26.)

Community Care Access Centres

The inquest heard a lot of testimony about the role of the Community Care Access Centre in the placement of Mr. Sandhu. Mr. Sandhu had had no contact with the Community Care Access Centre prior to his placement, and their knowledge of

² Commitment to Care: A Plan for Long-Term Care in Ontario, Spring, 2004, (Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care), <http://www.health.gov.on.ca/>, pg. 7 & 26.

him was only that which was collected from the doctor and various family members. Further, the placement was done in a short-time period as it was deemed an emergency, and there were questions about the process which took place.

The jury made a number of recommendations with respect to the completion of the application and placement of residents, to ensure that as much correct information as possible is obtained and that appropriate placements are made, so that the needs of all those requiring long-term care can be met. (Recommendations 53-60.)

CONCLUSION

The recommendations are far-reaching and will have a great impact on the lives of those living in long-term care if they are implemented. This is the opportune time for these recommendations to be considered, given the government's commitment to reforming the system. However, we must continue to keep these recommendations on the government's agenda, and lobby for their implementation. Full text of the Jury's recommendations from this inquest may be found at www.advocacycentreelderly.org/nursing/pubs.htm.