

They told her he died peacefully

BY SAM COOPER, THE PROVINCE OCTOBER 31, 2011



Gail Nelson in front of Sunrise of Lynn Valley care home in North Vancouver with documents that show the death of her father in the care home was not truthfully reported.

Photograph by: Arlen Redekop, PNG

Eldon Mooney, an 88-year-old who suffered from acute [dementia](#), did not die a natural death in his bed at a North Vancouver care home. He choked to death while being fed by an ill-trained caregiver who failed to respond in a “safe, efficient and effective manner.”

But if his daughter, Gail Nelson, had not secretly installed a video camera in his room, the lies about her father’s death would have been buried with him.

After a three-month [investigation into B.C.’s senior care system](#), *The Province* obtained documents on Mooney’s death, including a [B.C. coroner’s report](#), an inaccurate death certificate and the findings of a confidential investigation by Vancouver Coastal Health. Put together with a number of interviews and a review of video evidence, we can present the untold story of Mooney’s final minutes on the morning of Jan. 29, 2011, at [Sunrise of Lynn Valley](#), where his daughter says the cost of his care reached an estimated \$10,000 a month.

The privately run facility is owned by [Sunrise Senior Living](#), a Virginia-based company traded on the

New York Stock Exchange at a market capitalization of about \$300 million.

Following *The Province's* investigation into this story, the government and the official Opposition were presented with the facts and asked to comment. NDP health critic Mike Farnworth said the Mooney case must be reopened.

"I think clearly this has got to be thoroughly investigated," Farnworth said. "It's pretty disturbing that something like this would take place. Let's put it this way: I've never viewed choking as being a natural cause of death."

In a series of interviews, Nelson, a 60-year-old from Coquitlam, often sobbed.

"They lied to me. They said they came in that morning, and Dad was unconscious and he peacefully died," she cried. "My doctor told me, 'You've got to let this go.' But I'm one of those people that just cannot let this wrong lie stand. It would just eat away at me."

Nelson says her father — an electrician born on Prince Edward Island who worked for most of his life at Neptune Terminals in North Vancouver — wasn't easy to care for. After his wife, Antonetta, died in 2004, he suffered a brain injury and battled depression as his dementia progressed.

He didn't like caregivers, and his episodes of delirium could make him aggressive. That's why Nelson says she was willing to pay the high cost of his care at Sunrise.

In November 2010, the family visited Sunrise of Lynn Valley, which is licensed by [Vancouver Coastal Health](#), and together decided it was a good fit, with its homey rooms and non-institutional feel.

"This place was supposed to be specializing in dementia, and they assured us that they can manage," Nelson said. "Eldon said, 'I love it here.'"

Still, she wanted to be sure the home was providing the level of care promised. So she bought a "nanny cam" disguised as a clock radio, placed it in his room, and reviewed the footage as often as she could.

Nelson says she became convinced her father had to be moved elsewhere.

She felt staff "were just not taking care of him," Nelson said. "But the thing is, I had no place to move him to."

When she was informed of her father's death, she went straight to Sunrise. She says what she was told by the caregiver didn't make sense.

After scanning through hours of video at home, Nelson found evidence that she says "shocked and devastated" her.

Nelson describes the video evidence of her father's accidental death like this: "She just started feeding him from a bowl and then you can see him start to cough a bit . . . she went and got him a glass of water. . . that's the worst thing you can do, and he gets even worse. She goes and gets a waste-paper basket and brings it to him."

"He's trying to grab the pail and throw up in it . . . he's grabbing it and trying to pull himself up . . . well, she slightly pushes him back . . . the next thing you know, Dad's head drops, and I think that was the time he died."

The Province has reviewed the video evidence in which a care aide appears to be more concerned about avoiding a mess than helping Mooney clear his throat. Mooney repeatedly tries to rise from his pillow to a sitting position, without help from the care aide, who instead pats him on the shoulder and pushes a bucket close to his face.

After watching the video, Nelson called the coroner's office on Jan. 30 and alleged Sunrise had failed to provide appropriate first aid as her father choked to death; that Sunrise staff had lied about the manner of death; and that Mooney was not monitored as agreed with Sunrise and was inadequately cared for.

"If I didn't have a video, I don't think anything would have happened with the coroner," Nelson said.

The report into Mooney's death by coroner Kate Corcoran suggests Nelson is right.

"The video confirms that some of SLV's staff members were less than forthcoming with the facts surrounding Mr. Mooney's final minutes, leaving management unaware of the correct circumstances," Corcoran writes. "Mr. Mooney's death was the result of a choking incident during breakfast; an incident not responded to in a safe, efficient and effective manner."

Corcoran concludes that: "Mr. Mooney was a challenging patient to care for, and staff was ill prepared and incapable of dealing with his issues — issues known to exist in the elderly and vulnerable population that facilities such as Sunrise of Lynn Valley cater to. If not for the video brought forward by the family, Mr. Mooney's accidental death would not have surfaced."

Corcoran writes that because of the divergence between Nelson's story and the Sunrise staff version of the death — judged to be natural and likely due to a "cardiac event" in the official medical death certificate of Sunrise's doctor, dated Jan. 31, 2011 — Mooney's body was sent to Vancouver General Hospital for a forensic examination.

Documents show that forensic pathologist Charles Lee said the video "revealed a patient going into distress, apparently trying to cough shortly before becoming unconscious while being fed by a staff member."

Lee found that Mooney had a “massive amount of partially chewed food in the airways.”

After the finding, Corcoran had medical charting evidence at Sunrise seized and Vancouver Coastal Health licensing was “immediately notified.”

Coastal Health licensing investigators found 23 breaches of care involving Mooney and other patients, according to an investigative report dated April 12 this year.

The report says that in the years preceding Mooney’s death, Sunrise had received “numerous visits . . . to assist the licensee in understanding the need to report incidents” and improve care plans.

On Nov. 21, 2008, Coastal Health followed up on an incident involving a resident fall and appropriate action was not taken, according to the report. It was found Sunrise did not have adequate training and skills to deal with the emergency incident and supervision of staff was not adequate. The facility put a new policy in place to address the contravention, the report says.

Next, on Aug. 9, 2010, an investigation proved allegations true that Sunrise didn’t have adequate supervisory staff to meet the needs of a resident with aggressive behaviour, did not ensure staff had adequate training and skills and did not inform responsible parties of the changing needs of the resident. Sunrise put in an action plan to educate staff regarding dementia and delirium and improved the availability of supervisory staff, according to the report.

However, these same issues seem to have arisen in Mooney’s case.

A detailed list of facts uncovered in the Vancouver Coastal Health investigation of Mooney’s case, which found 23 contraventions of the [Community Care and Assisted Living Act](#), is listed separately at right.

“The staff present at the death of the resident reported to the licensee that the resident was found in bed with no respirations,” the report found. “This statement was not truthful and shows lack of good character of the staff.”

In response to interview requests, Sunrise Senior Living forwarded a statement to *The Province*: “We cherish each and every one of our residents. This was a tragic incident that is not at all representative of the care we give at Sunrise. We confront any shortcomings vigorously and respond proactively to help ensure we are providing our residents with the very best home.”

Vancouver Coastal Health spokesperson Anna Marie D’Angelo was asked to comment.

“As far as [the Sunrise staff] action goes, it is an appalling incident,” she said. “We did investigate thoroughly the circumstances surrounding this death at the care home and we did identify serious contraventions of the Community Care and Assisted Living Act. We are working with the operator to make sure the facility is in compliance with the act.

“Our inspectors believe the facility has recognized the seriousness of this matter and has made a considerable effort to prevent it from happening again.”

D’Angelo said there were “personnel changes” following Mooney’s death.

Documents say Sunrise has made “numerous and timely improvements” around procedures and training and has hired 24-hour on-site nursing care.

Gail Nelson says she has never received an apology from Sunrise or Vancouver Coastal Health. She questions how many other families in B.C. are unaware of the true nature of deaths in care homes. The Crown should have investigated the case, she believes.

“I’m getting the impression this province really doesn’t value seniors,” she said. “I was told a couple weeks ago I’m highly restricted even suing, because of the wrongful death laws in B.C. I was so outraged. How in heavens can that happen?”

In an interview, Health Minister Mike de Jong was asked to comment on the Mooney death and Gail Nelson’s complaints.

“I’m not in a position to make a comment on the specific case,” de Jong said. “[But] I believe we do need to look at our laws in B.C. I believe they are increasingly out of step with wrongful death laws in other jurisdictions.”

scooper@theprovince.com

twitter.com/scoopercooper

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