VERDICT OF CORONER'S JURY

We
Margaret PERGERON of OTTAWA, ONTARIO
Tom BROCK of OTTAWA, ONTARIO
Laura COLLIER of OTTAWA, ONTARIO
Peter PLAVEC of OTTAWA, ONTARIO
Earl CAMPION of OTTAWA, ONTARIO

the jury serving on the inquest into the death of: Mark Alexander WIENS
aged 23 held at Canadian Human Rights Tribunal, 160 Elgin Street
OTTAWA, Ontario

on the 27th day of September, 2004

by Dr. A. McCALLUM, Regional Coroner for Ontario

having been duly sworn have inquired into and determined the following:

1. Name of deceased: Mark Alexander WIENS
2. Date and time of death: 28 MAY 2002 AT APPROX 1915 HRS
3. Place of death: Eastbound Lanes of the 417 Highway
   at the Carling Avenue on-ramp in Ottawa Ontario
4. Cause of death: Lethal blunt impact injury to the
   head and chest

5. By what means: Accident

This verdict was received by me this 19th day of October, 2004

B.M.B.P.
Deputy Chief Coroner of Inquests

Dr. Andrew McCALLUM
Regional Coroner, Area 16

Office of the Chief Coroner
WE THE JURY WISH TO OFFER OUR SINCERE CONDOLENCES TO THE FAMILY AND FRIENDS OF MARK WIENS. WE ARE HOPEFUL THAT THE IMPLEMENTATION OF OUR RECOMMENDATIONS WILL HELP PREVENT SIMILAR TRAGEDIES IN THE FUTURE.

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS, IN NO PARTICULAR ORDER OF PRIORITY:

A. Directed to the Ministry of Health and Long Term Care

MENTAL HEALTH ACT AND THE HEALTH CARE CONSENT ACT

Context: We observed through testimony that the Mental Health Act and the Health Care Consent Act were open to subjective interpretation, difficult to understand and did not encompass the use of some common terminology (i.e. High Risk Voluntary Patients). As a result, provisions of the Acts were not utilized as effectively as possible.

1 Recommendation We the jury recommend that the Ministry of Health and Long Term Care review the Mental Health Act and the Health Care Consent Act to:

   a) Establish a consistent interpretation for medical practitioners, family and patients on the application of capacity, incapacity, voluntary and involuntary status.

   b) Ensure clarity to provide easily understood legislation.

   c) Address High Risk Voluntary Patients and establish guidelines surrounding their safety and care.

   d) Extend the services of a legal rights advisor to Substitute Decision Makers.

2 Recommendation As it applies to resource levels, we the jury recommend that the Ministry of Health and Long Term Care increase funding levels to the Royal Ottawa Hospital to assist them in the implementation of these recommendations on training, safety and security issues.

B. Directed to the Colleges governing Health Care Practitioners

3 Recommendation We the jury recommend that the applicable governing bodies of Health Practitioners provide on-going guidance through training packages and training sessions on the provisions of the Acts.
C. Directed to the Royal Ottawa Hospital

ROYAL OTTAWA HOSPITAL POLICIES

General

Context: Testimony demonstrated a subjective interpretation and inconsistent application of the policies.

4 **Recommendation** We the jury recommend all policies be reviewed for clarity and consistency and include a “Definitions” section, where applicable, where terms used in the policy may be defined.

5 **Recommendation** We the jury recommend the adoption of a standard document control system for policies and procedures. Changes to the current policy documents would include the following:

   a) A “Cross Reference” block.
   b) A “Next Review Date” block.
   c) A block that clearly identifies the document being replaced.

Charting Policy

Context: There was evidence presented that despite charting policies in place as promulgated by the College of Nurses of Ontario, charting practices at the time lacked sufficient detail and clarity to adequately assess treatment progress or fully appreciate the severity of incidents or events on the overall treatment plan. For example, on a daily basis it was unclear as to what a patient’s status was, their daily level of responsibility or what critical incidents may have occurred.

6 **Recommendation** We the jury recommend that an auditing process be implemented, as set out in the College of Nurses of Ontario *Standards of Nursing Documentation*, to ensure that the charting policies and procedures are being followed.

7 **Recommendation** We the jury recommend that Interdisciplinary Progress Notes routinely include observations by any visiting Assertive Community Treatment team members.
Levels of Responsibility Policy

Context: We heard through testimony that this policy is generalized and does not take into account individual patient needs. There is no distinction between involuntary, voluntary, high risk voluntary patients and patients that are incapacitated in regards to treatment. In addition, we heard that Levels Of Responsibilities have a therapeutic value towards a patient's treatment. Through review of the Interdisciplinary Progress Notes there is a lack of charting on patients use or compliance with Levels Of Responsibilities or on the criteria for setting a Level Of Responsibility. Without proper charting and monitoring of the use of these levels, the therapeutic values are not obvious.

Recommendation  We the jury recommend that the Level of Responsibility policy be modified for greater supervision of High Risk Voluntary Patients and voluntary patients that are incapacitated in regards to treatment.

Recommendation  We the jury recommend that the policy include mechanisms to enforce compliance with the Levels Of Responsibilities and that consequences be established for failure to comply.

Recommendation  We the jury recommend that an additional Level of Responsibility be included to allow unsupervised access to a secure area on the hospital grounds.

Recommendation  We the jury recommend that monitoring the use and abuse of Levels Of Responsibilities be included as part of the patient treatment plan, be recorded in the patients chart and be made available to family members designated as Substitute Decision Makers.

Recommendation  We the jury recommend that the patients' charts clearly illustrate the use of Levels Of Responsibilities over the course of treatment. This should include written justification for increases in Levels Of Responsibilities, the date, the time and ordering physician. This information should be located in a section of the patient chart that can be easily accessed and followed.

Unauthorized Leave Policy

Context: We have heard testimony that occurrences of unauthorized leave are not documented regularly, the actual number is unknown and that Incident Reports are not consistently completed. We further heard that the current policy does not apply to voluntary patients.
Recommendation We the jury recommend that the policy be updated to clarify its application to voluntary patients.

Recommendation We the jury recommend the enforcement of the use of a logbook to regularly record time out, destination and time in of each patient.

Recommendation We the jury recommend that the number of occurrences of unauthorized leave be recorded and reported monthly to the appropriate authority for review and follow-up.

Recommendation We the jury recommend that health practitioners complete Incident Reports, as outlined in the Unauthorized Leave Policy, without exception, and that this be documented in Interdisciplinary Progress notes.

Intermittent Observation Policy

Context: The policy in effect during April/May 2002 had no requirement to document the results of an intermittent observation. The revised policy sets out the requirement to document Intermittent Observation using the 'Intermittent Observation Record'. However, the Jury observed that in the revised policy the term ‘emergency’ is used in the Policy statement but is not defined and the term ‘constant observation’ is incorrectly used in the Procedures block.

Recommendation We the jury recommend that the current Intermittent Observation policy be amended to define “emergency” and delete the term “constant observation”.

Use of Restraints Policy

Context: The Use of Restraints policy in effect during April/May 2002 included the requirement to complete an evaluation for certification in the case of a Voluntary/Non-Certified patient. The revised policy is written in greater detail and:

- includes the requirement, in part, to ‘if necessary, notify the treating physician……’;
- includes meeting with the patient and family regarding the reasons for restraint;
- but does not include the requirement for an evaluation for certification.
Recommendation We the jury, recommend that the Use of Restraints policy be amended to reflect:

a) The **immediate** notification of a physician when a restraint is used, or is intended to be used, vice "if necessary".

b) That the patients' primary physician (or the officially designated replacement physician) documents the need for certification, or the rationale for not certifying.

High Risk Voluntary Patient Policy

Context: The High Risk Voluntary Patient policy allows the designation to expire after 4 days unless renewed.

Recommendation We the jury, recommend that the High Risk Voluntary Patient status remain in effect until a physician, in writing, removes it.

TRAINING ON ROYAL OTTAWA HOSPITAL POLICIES

Context: We heard through the testimony that training on Royal Ottawa Hospital policies was sporadic and varied across the disciplines with no evidence of a formal training program.

Recommendation We the jury recommend that an interdisciplinary training coordinator function be established to provide over-arching management and focus on all policies and procedures.

Recommendation We the jury recommend that a formal training program be established for all medical and nursing staff (including orderlies) and appropriately funded.

Recommendation We the jury recommend the establishment of a mandatory monitoring program of all training undertaken with respect to Royal Ottawa Hospital policies for all indeterminate, part-time and casual nursing staff, orderlies, support staff and medical practitioners.
SAFETY AND SECURITY OF PATIENTS

Context: Due to the vastness of the Royal Ottawa Hospital grounds and its close proximity to commercial and residential areas, patient and public safety is paramount. We have heard testimony that patient safety underlies every policy and that all staff are responsible for patient safety and security once admitted. We also heard that the Royal Ottawa Hospital has recently identified funding for a position dedicated to Safety and Security. We heard testimony that there are high proportions of patients who smoke on ward CB5, as was the case in 2002. The non-smoking by-law currently in place dictated the closing of the smoking lounge for CB5 patients, removing a safe and secure smoking environment.

Recommendation  We the jury recommend the creation of a secure monitored area on the grounds to ensure the safety of the patients.

Recommendation  We the jury recommend the immediate appointment of the safety officer position.

Recommendation  We the jury recommend an Incident Report Policy be developed to address all aspects of patient safety and establish the criteria for minor and major incidents.

COMMUNICATION AND AWARENESS

Context: There appeared to be no mechanism for the involvement of patients’ family members in the formulation of hospital policies and procedures.

Recommendation  We the jury recommend the creation of an Advisory Council made up of volunteer family members of hospital clients. This Advisory Council will work in partnership with the hospital to ensure quality care for their relatives faced with mental illness.

D. Conclusion Directed to the Ministry of Health and Long Term Care, the Colleges governing Health Care Practitioners and the Royal Ottawa Hospital

Recommendation. We the jury recommend that both the Ministry of Health and Long Term Care and the Royal Ottawa Hospital report to the Chief Coroner’s office one year from the release of the jury’s recommendations with respect to the implementation status of these recommendations. The results should be made available to the public.
Inquest into the death of Mark Wiens

Coroner's Explanation of Jury Verdict

I intend to give a brief synopsis of issues presented at the inquest into the death of Mark Wiens and explain in some detail the reasons for the jury's recommendations. I would like to stress that much of this will be my interpretation of the jury's reasons. The sole purpose of this is to assist the reader to more fully understand the verdict and the recommendations of the jury. It is not intended to be considered as actual evidence presented at the inquest. It is in no way intended to replace the jury's verdict.

The jury rendered its verdict as follows:

Name of deceased: Mark Alexander WIENS

Date and time of death: 28 MAY 2002 AT APPROX 1915 HRS

Place of death: Eastbound Lanes of the 417 Highway at the Carling Avenue on-ramp in Ottawa Ontario

Cause of death: Lethal blunt impact injury to the head and chest

By what means: Accident

The jury made a number of recommendations and I have added an explanatory note where appropriate. I have interpreted the jury's explanations, and I am responsible for any error in so doing.

A. Directed to the Ministry of Health and Long Term Care

MENTAL HEALTH ACT AND THE HEALTH CARE CONSENT ACT

Context: We observed through testimony that the Mental Health Act and the Health Care Consent Act were open to subjective interpretation, difficult to understand and did not encompass the use of some common terminology (i.e. High Risk Voluntary Patients). As a result, provisions of the Acts were not utilized as effectively as possible.
Inquest into the death of Mark Wiens

Recommendation 1. We the jury recommend that the Ministry of Health and Long Term Care review the Mental Health Act and the Health Care Consent Act to:

a) Establish a consistent interpretation for medical practitioners, family and patients on the application of capacity, incapacity, voluntary and involuntary status.

b) Ensure clarity to provide easily understood legislation.

c) Address High Risk Voluntary Patients and establish guidelines surrounding their safety and care.

d) Extend the services of a legal rights advisor to Substitute Decision Makers.

Recommendation 2. As it applies to resource levels, we the jury recommend that the Ministry of Health and Long Term Care increase funding levels to the Royal Ottawa Hospital to assist them in the implementation of these recommendations on training, safety and security issues.

Coroner’s Explanatory Note: The jury heard testimony from a number of witnesses as to their interpretation of the provisions of the Mental Health Act. There were significant disparities between these interpretations. Further, witnesses gave differing interpretations of the definitions and requirements under the Health Care Consent Act. The jury felt that greater clarity could be achieved by revision of the Acts in question and that better understanding of the Acts would be possible with enhanced training.

B. Directed to the Colleges governing Health Care Practitioners

Recommendation 3. We the jury recommend that the applicable governing bodies of Health Practitioners provide on-going guidance through training packages and training sessions on the provisions of the Acts.

Coroner’s Explanatory Note: The explanation for this recommendation flows from the recommendations in the previous section.
Inquest into the death of Mark Wiens

C. Directed to the Royal Ottawa Hospital

ROYAL OTTAWA HOSPITAL POLICIES

General

Context: Testimony demonstrated a subjective interpretation and inconsistent application of the policies.

Recommendation 4. We the jury recommend all polices be reviewed for clarity and consistency and include a “Definitions” section, where applicable, where terms used in the policy may be defined.

Recommendation 5. We the jury recommend the adoption of a standard document control system for policies and procedures. Changes to the current policy documents would include the following:

a) A “Cross Reference” block.
b) A “Next Review Date” block.
c) A block that clearly identifies the document being replaced.

Coroner’s Explanatory Note: The policies presented in evidence varied in form and content. There did not appear to be a standard format. It was difficult for the jury to ascertain the valid date and revision date of the policies.

Charting Policy

Context: There was evidence presented that despite charting policies in place as promulgated by the College of Nurses of Ontario, charting practices at the time lacked sufficient detail and clarity to adequately assess treatment progress or fully appreciate the severity of incidents or events on the overall treatment plan. For example, on a daily basis it was unclear as to what a patients’ status was, their daily level of responsibility or what critical incidents may have occurred.

Recommendation 6. We the jury recommend that an auditing process be implemented, as set out in the College of Nurses of Ontario Standards of Nursing Documentation, to ensure that the charting policies and procedures are being followed.
Inquest into the death of Mark Wiens

Recommendation 7. We the jury recommend that Interdisciplinary Progress Notes routinely include observations by any visiting Assertive Community Treatment team members.

Coroner's Explanatory Note: At the time of the incident, the nurses were using a concept of documentation known as "Charting by Exception". This practice required that only changes from normal or expected status of patients be documented. The practice has since been discontinued.

Levels of Responsibility Policy

Context: We heard through testimony that this policy is generalized and does not take into account individual patient needs. There is no distinction between involuntary, voluntary, high risk voluntary patients and patients that are incapacitated in regards to treatment. In addition, we heard that Levels Of Responsibilities have a therapeutic value towards a patient’s treatment. Through review of the Interdisciplinary Progress Notes there is a lack of charting on patients use or compliance with Levels Of Responsibilities or on the criteria for setting a Level Of Responsibility. Without proper charting and monitoring of the use of these levels, the therapeutic values are not obvious.

Recommendation 8. We the jury recommend that the Level of Responsibility policy be modified for greater supervision of High Risk Voluntary Patients and voluntary patients that are incapacitated in regards to treatment.

Recommendation 9. We the jury recommend that the policy include mechanisms to enforce compliance with the Levels Of Responsibilities and that consequences be established for failure to comply.

Recommendation 10. We the jury recommend that an additional Level of Responsibility be included to allow unsupervised access to a secure area on the hospital grounds.

Recommendation 11. We the jury recommend that monitoring the use and abuse of Levels Of Responsibilities be included as part of the patient treatment plan, be recorded in the patients chart and be made available to family members designated as Substitute Decision Makers.

Recommendation 12. We the jury recommend that the patients' charts clearly illustrate the use of Levels Of Responsibilities over the course of
treatment. This should include written justification for increases in Levels Of Responsibilities, the date, the time and ordering physician. This information should be located in a section of the patient chart that can be easily accessed and followed.

Coroner’s Explanatory Note: There was considerable controversy in the evidence about the use of Levels of Responsibility. In the case of the deceased, while the general principle was that a patient would rise through the Levels in a gradual fashion, he was accelerated from Level 2 to Level 5. The reason given was that his illness did not allow him to be at Level 3 and/or 4. Given that difficulty, the deceased did not appear to be well served by the Levels of Responsibility as they were set out at the time of his death.

Furthermore, the jury heard confusing testimony about the relationship of the Levels of Responsibility and patient capacity. High Risk Voluntary Patients did not appear to be treated differently under the Level of Responsibility Policy than voluntary patients. Some witnesses did not appear in their evidence to consider capacity as a factor in the assignment of Level of Responsibility. The progress notes did not always reflect the thought process of the physician in choosing a particular Level.

Unauthorized Leave Policy

Context: We have heard testimony that occurrences of unauthorized leave are not documented regularly, the actual number is unknown and that Incident Reports are not consistently completed. We further heard that the current policy does not apply to voluntary patients.

Recommendation 13. We the jury recommend that the policy be updated to clarify its application to voluntary patients.

Recommendation 14. We the jury recommend the enforcement of the use of a logbook to regularly record time out, destination and time in of each patient.

Recommendation 15. We the jury recommend that the number of occurrences of unauthorized leave be recorded and reported monthly to the appropriate authority for review and follow-up.
Inquest into the death of Mark Wiens

Recommendation 16. We the jury recommend that health practitioners complete Incident Reports, as outlined in the Unauthorized Leave Policy, without exception, and that this be documented in Interdisciplinary Progress notes.

Coroner's Explanatory Note: Testimony indicated that there are frequent but undocumented unauthorized patient absences. Further, the staff who testified appeared to believe that the documentation of absences among voluntary patients is not required, though there is a policy requiring documentation thereof. There did not appear to be a clear understanding of the distinction between voluntary competent patients, versus voluntary incapacitated patients. This was manifested in the lack of difference between these two groups with respect to surveillance of their movements.

The jury made its recommendations in this area to assist the hospital in quantifying the problem. The magnitude of the problem is unknown at present.

Intermittent Observation Policy

Context: The policy in effect during April/May 2002 had no requirement to document the results of an intermittent observation. The revised policy sets out the requirement to document Intermittent Observation using the 'Intermittent Observation Record'. However, the Jury observed that in the revised policy the term 'emergency' is used in the Policy statement but is not defined and the term 'constant observation' is incorrectly used in the Procedures block.

Recommendation 17. We the jury recommend that the current Intermittent Observation policy be amended to define "emergency" and delete the term "constant observation".

Coroner's Explanatory Note: The jury recognized an inconsistency in the current "Intermittent Observation Policy" and recommended the correction thereof.

Use of Restraints Policy

Context: The Use of Restraints policy in effect during April/May 2002 included the requirement to complete an evaluation for certification in the
Inquest into the death of Mark Wiens

case of a Voluntary/Non-Certified patient. The revised policy is written in greater detail and:

- includes the requirement, in part, to 'if necessary, notify the treating physician...';
- includes meeting with the patient and family regarding the reasons for restraint;
- but does not include the requirement for an evaluation for certification.

Recommendation 18. We the jury, recommend that the Use of Restraints policy be amended to reflect:

a) The immediate notification of a physician when a restraint is used, or is intended to be used, vice "if necessary".

b) That the patients' primary physician (or the officially designated replacement physician) documents the need for certification, or the rationale for not certifying.

Coroner's Explanatory Note: An expert in psychiatry testified that violent agitation is one of the true emergency situations in psychiatry. Thus, he stated that notification of the attending physician at the earliest time possible after the onset of the situation is essential. Further, the physician so notified is in a better position to assess the patient and plan treatment. Though there is and was a policy in place requiring the notification of the attending physician or delegate, this policy was widely interpreted to mean that night-time incidents could be drawn to the duty doctor's attention the following morning. The jury wished to make clear the need to immediately notify the duty doctor in accord with this expert opinion.

High Risk Voluntary Patient Policy

Context: The High Risk Voluntary Patient policy allows the designation to expire after 4 days unless renewed.

Recommendation 19. We the jury, recommend that the High Risk Voluntary Patient status remain in effect until a physician, in writing, removes it.
inquest into the death of Mark Wiens

Coroner’s Explanatory Note: The jury heard evidence that these High Risk patients’ status automatically lapsed unless renewed after four days. The jury made the recommendation to reverse this, in order to enhance the safety of these patients by ensuring that the status reversal would require a conscious decision on the part of the physician.

TRAINING ON ROYAL OTTAWA HOSPITAL POLICIES

Context: We heard through the testimony that training on Royal Ottawa Hospital policies was sporadic and varied across the disciplines with no evidence of a formal training program.

Recommendation 20. We the jury, recommend that an interdisciplinary training coordinator function be established to provide over-arching management and focus on all policies and procedures.

Recommendation 21. We the jury, recommend that a formal training program be established for all medical and nursing staff (including orderlies) and appropriately funded.

Recommendation 22. We the jury recommend the establishment of a mandatory monitoring program of all training undertaken with respect to Royal Ottawa Hospital policies for all indeterminate, part-time and casual nursing staff, orderlies, support staff and medical practitioners.

Coroner’s Explanatory Note: The jury heard repeated evidence that policies were in place but staff did not either comply with them or understand their obligations under the policies. Their recommendations in this area are directed at systematizing and making uniform the policies and procedures of the hospital.

SAFETY AND SECURITY OF PATIENTS

Context: Due to the vastness of the Royal Ottawa Hospital grounds and its close proximity to commercial and residential areas, patient and public safety is paramount. We have heard testimony that patient safety underlies every policy and that all staff are responsible for patient safety and security once admitted. We also heard that the Royal Ottawa Hospital has recently identified funding for a position dedicated to Safety and Security. We heard testimony that there are high proportions of patients who smoke on ward CB5, as was the case in 2002. The non-
Inquest into the death of Mark Wiens

smoking by-law currently in place dictated the closing of the smoking lounge for CB5 patients, removing a safe and secure smoking environment.

Recommendation 23. We the jury recommend the creation of a secure monitored area on the grounds to ensure the safety of the patients.

Recommendation 24. We the jury recommend the immediate appointment of the safety officer position.

Recommendation 25. We the jury recommend an Incident Report Policy be developed to address all aspects of patient safety and establish the criteria for minor and major incidents.

Coroner's Explanatory Note: The jury recognized that safety for patients will best be served by a systems approach. Simply increasing vigilance on the part of individual health care providers will not suffice. A patient safety coordinator will be able work broadly to promote cultural change in the organization to foster safety systems, an analytical and introspective approach to safety and to increase awareness of high-hazard situations such as that posed by incapacitated patients who leave the hospital grounds.

The evidence was that smoking has been banned on the ward that serves as residence to a population that has been estimated to include 75 – 80 % smokers. This clearly represents a situation wherein patients are at risk, by virtue of the requirement that they leave the premises to smoke. While no-one would deny the long-term health risk of smoking, the immediate risk of harm to vulnerable patients must also be considered, especially when they are resistant to smoking cessation interventions by reason of their illness.

COMMUNICATION AND AWARENESS

Context: There appeared to be no mechanism for the involvement of patients’ family members in the formulation of hospital policies and procedures.

Recommendation 26. We the jury recommend the creation of an Advisory Council made up of volunteer family members of hospital clients. This Advisory Council will work in partnership with the hospital to ensure quality care for their relatives faced with mental illness.
Coroner’s Explanatory Note: The jury heard diverging views regarding the involvement of substituted decision makers in the care and in the consent to care of the deceased. Also, there did not appear to be a forum for the concerns of the loved ones of patients to be heard.

D. Conclusion Directed to the Ministry of Health and Long Term Care, the Colleges governing Health Care Practitioners and the Royal Ottawa Hospital

Recommendation 27 We the jury recommend that both the Ministry of Health and Long Term Care and the Royal Ottawa Hospital report to the Chief Coroner’s office one year from the release of the jury’s recommendations with respect to the implementation status of these recommendations. The results should be made available to the public.

Coroner’s Explanatory Note: This section is self-explanatory.
Inquest into the death of Mark Wiens

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury's verdict. It is worth repeating that it is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I have made a gross error in my recollection of the evidence or a conclusion of the jury, it would be greatly appreciated if it could be brought to my attention and I will correct the error forthwith.

Andrew McCallum, MD
Presiding Coroner