RELEASE DATE: JUNE 16, 2017

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: RONALD BOBBIE (DOD: September 26, 2014)

Report on Inquest of Judge Lindy Choy
Issued this 13th day of June, 2017

APPEARANCES:

VALERIE A. HEBERT & SIVANANTHAN SIVAROUBAN, Inquest counsel
ROBIN P. J. WINTERS & ALAN J. LADYKA, Counsel for Manitoba Health, Seniors and Active Living (Selkirk Mental Health Centre)
DANIEL P. RYALL, Counsel for Winnipeg Regional Health Authority
G. TODD CAMPBELL, Counsel for Dr. Kremer
KIMBERLY D. CARSWELL, Counsel for City of Winnipeg
M. BETH TAIT, counsel for Royal Canadian Mounted Police

RELEASE DATE: JUNE 16, 2017

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: RONALD BOBBIE

Having held an inquest respecting the said death on December 6, 8, 12, 13, 15, 2016, March 10 and April 11, 2017 at the City of Winnipeg, and on February 10 and March 3, 2017 in the Town of Selkirk, in Manitoba, I report as follows:

The name of the deceased is: RONALD BOBBIE.

The deceased came to his death on the 26th day of September, 2014.

Attached hereto and forming part of my report is a list of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 13th day of June, 2017.

"*Original signed by Judge Lindy Choy*"

Judge Lindy Choy

Copies to:
1. Dr. John Younes, A/Chief Medical Examiner (2 copies)
2. A/Chief Judge Shauna Hewitt-Michta, Provincial Court of Manitoba
3. The Honourable Heather Stefanson, Minister Responsible for *The Fatality Inquiries Act*
4. Ms. Julie Frederickson, Deputy Minister of Justice & Deputy Attorney General
5. Mr. Michael Mahon, Assistant Deputy Attorney General
6. Valerie A. Hebert & Sivananthan Sivarouban, Inquest counsel
7. Kevin Bobbie, brother of deceased
8. Pharus Bobbie, daughter of deceased
9. Robin P. J. Winters & Alan J. Ladyka, Counsel for Manitoba Health, Seniors and Active Living (Selkirk Mental Health Centre)
10. Daniel P. Ryall, Counsel for Winnipeg Regional Health Authority
11. G. Todd Campbell, Counsel for Dr. Kremer
12. Kimberly D. Carswell, Counsel for City of Winnipeg
13. M. Beth Tait, counsel for Royal Canadian Mounted Police
14. Exhibit Coordinator, Provincial Court
15. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: RONALD BOBBIE

TABLE OF CONTENTS

I. MANDATE OF INQUEST

[1] On September 26, 2014, Ronald Bobbie was pulled from the Red River just north of the Redwood Bridge in Winnipeg, Manitoba by Winnipeg Fire Paramedic Services. Witnesses saw him in the river yelling for help and called 911. Cardiopulmonary resuscitation was commenced and he was taken to St. Boniface Hospital, but unfortunately he could not be revived. Immediate cause of death was drowning. At the time of his passing, Mr. Bobbie was an involuntary resident of a psychiatric facility, namely, Forensic Unit 14 at Selkirk Mental Health Centre ("SMHC") in Selkirk, Manitoba. He had been there for 12 years. In 2002 he had been charged with arson related offences and was declared to be not criminally responsible. He had remained an involuntary resident at SMHC until the time of his passing.

[2] By letter dated June 26, 2015 the Chief Medical Examiner of the Province of Manitoba directed that an inquest to be held into the death of Ronald Bobbie for the following reasons:

> 1. To fulfill the requirement for an inquest, as defined in Section 19(3)(a) of *The Fatality Inquiries Act* (the "Act"):
>
> > Inquest Mandatory
> >
> > 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
> >
> > (a) that a person while resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in The Mental Health Act, or while a resident in a developmental centre as defined in The Vulnerable Persons Living with a Mental Disability Act, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> >
> > (b) that person died as a result of an act or omission of a peace officer in the course of duty;
> >
> > the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.
>
> 2. To determine the circumstances relating to his death, including the practice of issuing passes to involuntary residents of mental health centres in Manitoba; and
>
> 3. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

II. PARTIES

[3] Valerie Hebert and Sivananthan Sivarouban were appointed Inquest Counsel. Prior to the hearing, standing was granted pursuant to section 28(1) of the Act to:

- Province of Manitoba Department of Health, Healthy Living and Seniors (Selkirk Mental Health Centre) represented by Alan Ladyka and Robin Winters;
- Winnipeg Regional Health Authority and St. Boniface General Hospital, represented by Daniel Ryall;
- Dr. Steven Kremer, represented by G. Todd Campbell;
- Royal Canadian Mounted Police, represented by Beth Tait;
- Winnipeg Police Service and Winnipeg Fire Paramedic Service represented by Kimberly Carswell;
- Kevin Bobbie, representative of the family of Ronald Bobbie.

[4] The inquest took place over 9 days of hearing conducted in Winnipeg and in Selkirk and was completed April 11, 2017. Eighteen witnesses gave evidence at the inquest, including first responders, family members, Mr. Bobbie's treating psychiatrist, members of the SMHC treatment team and members of the SMHC administrative team. A list of the witnesses who testified at the Inquest is attached as Appendix "B".

[5] This report will first review the circumstances leading up to and surrounding Mr. Bobbie's death and the emergency response. The report will then examine aspects of the care received by Mr. Bobbie at SMHC, including the practice of issuing passes to involuntary forensic patients and SMHC's approach to absent without leave ("AWOL") patients. The specific treatment provided by Dr. Kremer and SMHC staff to Mr. Bobbie will be considered, taking into account the perspectives of the family and the treatment team. Finally, the report will address recommendations for changes in programs, polices or practices of mental health centres in Manitoba which would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in Mr. Bobbie's death.

III. RONALD BOBBIE'S BACKGROUND

[6] The following background facts are uncontroversial. At the time of his death, Ronald Bobbie was 59 years old. He was the second youngest of five siblings. His father died when he was young but his mother is still alive and resides in Winnipeg, Manitoba. Mr. Bobbie has a 25 year old daughter, Pharus Bobbie. Mr. Bobbie was first diagnosed with a psychological condition in the early 1980's. He suffered from rapid cycling bipolar disorder, formerly referred to as manic depression. When in a manic state, Mr. Bobbie's actions and behaviour would become unpredictable, his thinking disorganized, and he would be out of touch with reality. When depressed, he would become bedridden, staying in his room with impaired sleep and appetite.

[7] Mr. Bobbie was placed under the jurisdiction of the Criminal Code Review Board ("CRB") after being found not criminally responsible on account of mental disorder on August 12, 2002 in Manitoba Provincial Court. He had been charged with arson, uttering threats and breach of a family maintenance order.

[8] During the entire time Mr. Bobbie was under the jurisdiction of the CRB, he was placed at SMHC. While there he was classified as a forensic patient. Forensic patients at SMHC are placed in one of two units. Area 15 is a secure locked unit. When forensic patients are first admitted to SMHC, they are placed in the more restrictive Area 15.

[9] As time progresses, the patient may be transferred to Area 14. Area 14 is an open unit which is unlocked during the day but locked at night. The doors are secured at 9:00 p.m. and at that time, all in-patients must be back on the premises. At the time of his passing, Mr. Bobbie was a patient in Area 14. He had been in Area 14 since 2012.

[10] The last disposition made by the CRB regarding Mr. Bobbie was dated April 16, 2014. The order directed that Mr. Bobbie continue to be detained in custody in a hospital on conditions. In addition to conditions that he reside at SMHC, comply with the directions of and take medication prescribed by his treating psychiatrist, and not posses weapons, the CRB set guidelines with respect to pass privileges as follows:

> That upon the recommendations of the treatment team, the person in charge of the hospital may grant the following pass privileges:
>
> i) unsupervised full hospital grounds passes;
>
> ii) unsupervised passes to the City of Selkirk;
>
> iii) supervised day passes to the City of Winnipeg, which are to be supervised by hospital staff or by family members who have been approved by the treating psychiatrist;
>
> iv) supervised overnight passes to a maximum of two nights duration, which are to be supervised by family members who have been interviewed and approved by the treating psychiatrist;
>
> v) unsupervised passes to the City of Winnipeg, beginning at 6 hours duration and increasing incrementally to full day passes;
>
> subject to the provisions that the treatment team is of the opinion that Mr. Bobbie's mental condition is stable at the time of each pass and that it would be safe and appropriate to grant a pass;
>
> and
>
> That upon receipt of an updated assessment report (including a detailed community living plan if applicable), with notice and an opportunity to respond provided to counsel, the

> Board may consider and approve an increase in pass privileges, including an extended pass to reside in the community, subject to any further conditions deemed necessary and appropriate by the Board.

[11] In later 2013 or early 2014, the treatment team felt that Mr. Bobbie had been doing better overall. Despite residual symptomatology, they were hoping to move Mr. Bobbie towards reintegration into the community within the next six to eight months. A forensic community mental health specialist was assigned to Mr. Bobbie's case to explore supports in the community. The discussions contemplated having Mr. Bobbie either reside in Winnipeg or with his daughter, Pharus Bobie, in Dauphin.

[12] In early September 2014, the Winnipeg Regional Health Authority community health transition team was attempting to meet with Pharus Bobbie, but as at the time of Mr. Bobbie's passing, a meeting had not yet been coordinated.

[13] In the days leading to September 26, 2014, Mr. Bobbie had been struggling to comply with his treatment team regarding his participation in dialectical behaviour therapy or "DBT". The treatment team wanted Mr. Bobbie to participate as it was felt that DBT was critical to him learning skills to better manage his impulsivity and fluctuations in mood and to assist him in community placement and discharge from SMHC. In order to participate in DBT, Mr. Bobbie had to be present on ward to engage in the group sessions. Mr. Bobbie's preference was to visit with his family and therefore he frequently opted not to attend the DBT sessions, in favour of leaving SMHC and be with his family. He would do so even if he did not have pass privileges. Challenging authority was described as typical of Mr. Bobbie's personality. He was characterized as an individual who would consistently test limits.

[14] It was not unusual for Mr. Bobbie to be absent without leave or "AWOL" from SMHC. This could take two forms. First, there were occasions where Mr. Bobbie left SMHC when he did not have pass privileges to be absent. The other situation was where he was granted pass privileges but failed to report back to the ward at the designated time. Members of the treatment team indicated that Mr. Bobbie being AWOL in contravention of the parameters of his pass privileges was not a matter which would cause them alarm. Over time, Mr. Bobbie had established a pattern of consistently returning back to the ward by evening lock down. Further, he was usually in contact and could be reached on his cell phone. When Mr. Bobbie was located on these occasions, he was typically with his mother at her house or with another family member.

[15] As noted earlier, in the days and weeks before Mr. Bobbie's passing, he had been in conflict with his treatment team about his privileges and provision of day passes. The progress chart notes indicate that as of August 29, 2014, he had been given an increase in privileges to full unsupervised grounds access. By early September, the treatment team noted that his mood was escalating and privileges were scaled back to three 15 minute front step smoking privileges per shift. He had asked Dr. Kremer for a day pass to go visit his mother but this was refused because Mr. Bobbie was not settled. He then threatened to go AWOL. The progress notes describe him as being hypomanic with no insight into his behaviour. A high level of observation was commenced (every 15 minutes).

[16] From September 9 to 12, he was granted passes each day to spend time with family. As a result, he missed DBT sessions.

[17] September 13 to 15, he was granted a weekend pass to spend with family. Upon his return, his mood was noted to be low. This pattern of going from hypomanic to a low mood would be typical of Mr. Bobbie's diagnosis of rapid cycling bipolar disorder. His treatment providers indicated that he could cycle from one state to the next in a matter of hours or days.

[18] On September 17, Mr. Bobbie did not attend DBT as he remained in bed.

[19] On September 18, Mr. Bobbie requested a day pass to Winnipeg but was refused as he was not attending DBT sessions. At 11:30 am he was noted to be AWOL from the unit. By 1:30 pm, his family telephoned indicating that Mr. Bobbie was with them. He returned by 8:15 pm that evening.

[20] The next day, September 19, Mr. Bobbie was again refused a day pass for not participating in DBT. He left AWOL but returned that evening by 8:45 pm.

[21] September 21, Mr. Bobbie was out from 3:30 to 7:00 pm. He had been properly signed out.

[22] September 22, Mr. Bobbie was noted to be AWOL after lunch. At 3 pm, he called and said he was at his mother's house in Winnipeg and would return that evening. He was back by 8:00 pm.

[23] On September 23, a recovery and discharge planning meeting was held. Community reintegration was discussed. Mr. Bobbie was told that his passes into Winnipeg would be reinstated if he refrained from significant challenging behaviour.

[24] On September 24, Mr. Bobbie was noted in the progress notes as being argumentative and indicated that he wanted to quit DBT. He was not granted pass privileges but left anyways and was noted to be AWOL at 11:00 am. He returned that evening at 8:00 pm.

[25] As a result of the ongoing conflict regarding participation in DBT, Dr. Kremer gave verbal orders that Mr. Bobbie be confined to the ward with no privileges until he could be reassessed.

[26] On September 25, Mr. Bobbie was displeased when he was not allowed day pass privileges and so he refused to take his medications. He was noted to be AWOL later that morning. Dr. Kremer ordered that Mr. Bobbie be confined to the ward upon his return and that he was to remain on the ward until he could be assessed by a psychiatrist. A call was placed to Mr. Bobbie's mother who confirmed that he had been there and that he left at 6:30 to catch the bus back to Selkirk. Mr. Bobbie returned to the ward at 9:00 pm. His mood was noted to be low.

[27] Overall, in the days leading up to his death, Mr. Bobbie had been argumentative with his treatment team about the extent of his privileges. Although he was being considered for reintegration back to the community, and not considered a risk of danger to himself or to the public safety, the withholding of privileges was still being used by the treatment team to obtain compliance from Mr. Bobbie with respect to participation in DBT and taking his medications.

IV. EVENTS OF SEPTEMBER 26, 2014

[28] On September 26, 2014, Mr. Bobbie was under orders to be confined to the ward until he could be seen by Dr. Kremer. He spent the morning lying in bed, and was cooperative to remain in his pajamas on the ward. He was in a low mood and refused food and medications. The last time he was seen by the ward nurse was at about 12:30 or 12:45 p.m. Fifteen minutes later, the ward nurse looked for Mr. Bobbie again but was not able to find him. Mr. Bobbie's pajamas were found under his bed covers. A message was left by the ward nurse with Dr. Kremer on his answering machine at 1:00 p.m. At 3:00 p.m. Mr. Bobbie continued to be absent on the ward. At 3:45, Dr. Kremer was notified of Mr. Bobbie's current status and a verbal order was given that once Mr. Bobbie returned to the ward he was to be a day guest on A15 and to sleep on A14 once the doors were closed. At 6:30 p.m., Mr. Bobbie's mother called the ward stating that Mr. Bobbie had just left her house to take the 7:00 p.m. bus back to Selkirk. Unfortunately by 9:00 p.m., Mr. Bobbie had still not returned. At approximately 9:15 p.m., staff from St. Boniface Hospital Emergency Department called to notify of Mr. Bobbie's death.

A. Emergency Response

[29] At approximately 8:00 p.m., a 911 call was received. Witnesses on Talbot Avenue saw a man in the water in the river behind the houses. He yelled: "Help me please" and looked weak, putting his face up to try to stay above the water. The current pulled him under quite fast.

[30] First responders arrived on scene at 8:06 p.m. A command post was set up on Talbot and two rescue watercraft were deployed to the scene from the Redboine Docks at Churchill Drive, arriving by 8:26 p.m. Two fire engines were deployed to the base of the Redwood Bridge and visual scanning of the river was conducted by both Winnipeg Fire Paramedic Service and Winnipeg Police Service. At approximately 8:35 p.m., Mr. Bobbie was located in the river. He was brought aboard Water 131 and CPR was started. Mr. Bobbie was in cardiac arrest, with no breathing and no pulse. He was transferred to shore and in the ambulance, he was hooked up to EKG, IV access was gained and he was intubated. Despite continuous compressions and epinephrine every four minutes, there was no response to their lifesaving efforts and his cardiac status remained asystolic. Arrival at the St. Boniface emergency department was 9:04. Ronald Bobbie was pronounced dead at 9:18 p.m.

[31] When asked about the operations that day, the first responder witnesses did not identify any issues with the emergency response. District Chief Enns testified that he considered it to be a successful operation as they were able to locate the victim and make the rescue. When asked if he would do anything different he replied: "absolutely not." It is clear that the rescue of Mr. Bobbie from the river was executed in an efficient and competent manner. Winnipeg Fire Paramedic Services only perform 3 or 4 of these searches each year but it is apparent that they

were well prepared and able to perform their duties that day. It is only unfortunate that Mr. Bobbie had succumbed prior to their being able to locate and rescue him in the moving water.

V. TREATMENT RECEIVED BY MR. BOBBIE AT SMHC

[32] Mr. Bobbie had been a forensic patient at SMHC for 12 years. He had initially been placed on the secure locked facility on Area 15 and after 10 years was moved to the less restrictive Area 14. His psychiatric condition was described as "refractory" meaning that despite medications, he still had residual symptomatology. The goal with Mr. Bobbie's treatment was not to resolve the condition but rather to control it as much as possible. Dr. Steven Kremer became Mr. Bobbie's primary treating psychiatrist in 2006 and continued to treat Mr. Bobbie until his death 8 years later. Dr. Kremer described Mr. Bobbie's mental status as being worse in his earlier phases at SMHC than during the later time when Dr. Kremer knew him.

A. Risk of Suicide

[33] Risk of suicide was an issue which had arisen during Mr. Bobbie's time at SMHC, and while chronically present, it was not a dominant or prevalent theme in his treatment. There were two major incidents involving suicidal ideation while resident at SMHC.

[34] On September 23, 2011, Mr. Bobbie was involved in an incident where he had been rescued from the Red River. In later discussions with Dr. Kremer, Mr. Bobbie said that he had contemplated throwing himself into the river for many years and that day he felt compelled to do so. He had no explanation as to why and there were no particular stressors affecting him at the time.

[35] On June 22, 2012, Mr. Bobbie voiced suicidal ideations to staff. He had been AWOL and when on the telephone with his primary nurse he refused to reveal where he was and told her: "you'll find me floating down the river." Ultimately, RCMP apprehended Mr. Bobbie at a location beside the river. At the time, Mr. Bobbie had his privileges reduced due to subtherapeutic medication (lithium) levels in his bloodwork. He was advised that his privileges to go on passes would be withheld until there was normalization of his bloodwork to a therapeutic level. Upon return to SMHC, he was confined to Area 15 and placed on quarterly observations. By the time he met and was assessed by Dr. Kremer on June 26, 2012, he seemed stable in terms of mental status and was returned to Area 14.

[36] Given the existence of these two prior events, suicidal tendencies would always be something which the treatment team had to monitor. At the time of Mr. Bobbie's passing, however, he was not considered to be at elevated risk of suicide. Given the discharge planning which had been occurring, he was very future oriented, and suicide was not thought to be a significant risk at the time.

B. Practice of Issuing Passes to Involuntary Patients

[37] The inquest heard testimony from Dr. Murray Enns. Dr. Enns is a professor with the University of Manitoba Department of Psychiatry and a clinical staff psychiatrist with Access

Fort Garry and Deer Lodge Centre. He was not involved in Mr. Bobbie's treatment at SMHC. Dr. Enns spoke about how in the past number of decades the philosophy of care in mental health treatment has shifted from an incarceratory philosophy that emphasized safety at any cost to one which looks at mental health patients not as prisoners but as people with needs to be met. The goal is to grant autonomy where appropriate and to grant greater responsibility and liberties where appropriate. This is all in keeping with a philosophy of recovery, meaning to achieve the best that one can within the limits of the psychiatric condition that they have. There are moments in time in the trajectory of a person's illness where there might be a high risk of harm to self or others. Those moments in time, however, are restricted and outside of those moments, judiciously allowing privileges, including time away from the inpatient unit accomplishes a number of things. It allows the treatment team to evaluate a person and their state of wellness in a natural environment. It gives an opportunity for the person to experience greater latitude, and that may have an impact on their condition. It gives an opportunity to collect collateral information from people outside of the inpatient unit. Finally, it creates an atmosphere of collaborative and patient centred care, which promotes recovery.

[38] Dr. Enns testified that there is a tendency on average for patients to be treated more restrictively towards the beginning of their hospital stay, and then as they show settling and improvement, then greater and greater latitude is allowed. Patients would progress from being restricted to the unit, which may be locked, to being granted the ability to go for walks, to being granted longer privileges away from the unit, to being accompanied with a responsible adult, to more open passes that would allow them to stay out for longer periods of time and not necessarily require accompaniment.

[39] The process of granting increasing latitude is individualized, based on predictors of behaviour. It is a clinical decision based on input from an interdisciplinary team. There is a constant balancing of risk versus the need for the person to recover.

[40] In the context of a forensic patient under the jurisdiction of the CRB, the order issued from the CRB sets out the parameters of the patients' privileges and passes. The maximum limits are specified and then the treatment team may issue privileges within those parameters.

C. Granting of Privileges at SMHC

[41] Dr. Steven Kremer was Ronald Bobbie's treating psychiatrist and he testified as to the practice of issuing passes in Mr. Bobbie's situation. As Mr. Bobbie was under the jurisdiction of the CRB, the parameters of his liberty were set out in an annual disposition hearing order. Within those parameters, Dr. Kremer would issue a general order which would be recorded in Mr. Bobbie's chart. Dr. Kremer would not typically be involved in the decision to grant a pass on any particular day. The psychiatric nursing staff would be expected to interact with the patient and do a cursory mental health assessment. From there, the nursing staff would have the discretion to allow or deny utilization of the general orders with respect to granting a pass.

D. AWOL Policies

[42] SMHC has a formal policy which provides guidelines to follow when a forensic patient under the jurisdiction of the CRB is considered absent without leave. Upon establishing that a patient is absent from the assigned clinical area, staff are to complete a checklist. The checklist directs staff to notify the nurse in charge and organize a search of the SMHC grounds and immediate areas by contacting mobile support and security. The staff is next to contact the treating psychiatrist and the psychiatrist on call and obtain an order for the patient to be placed as AWOL. The testimony of the SMHC staff witnesses indicated that at this point, there is a level of discretion to be exercised by the psychiatrist. Once a patient is placed as AWOL, a Form #14 "Order for Return of Patient Absent without Permission" under The Mental Health Act is completed. A Form #14 is then forwarded to the local RCMP detachment along with a photograph of the patient to locate and return the patient to SMHC.

[43] Dr. Kremer's testimony was that while he had not reviewed the formal manuals specific to the SMHC AWOL policy, he did understand that when there was a patient with whereabouts unknown, the nursing staff would take steps to locate the patient and notify various individuals. He would be notified by staff and based on a number of factors including description of the individual, diagnosis, length of time at centre, medications, context of presentation, applicable risk factors etc he would make a decision as to whether or not to declare the patient AWOL. Generally speaking, he indicated that when deciding whether or not to make the declaration, his threshold was very low.

[44] On the day of Mr. Bobbie's death, Dr. Kremer testified that he had received information that Mr. Bobbie had left the ward as he had on many other occasions. At 3:45 pm, Dr. Kremer gave a verbal order to confine Mr. Bobbie as a day guest on the locked Unit 15. Dr. Kremer did not direct staff to fill out a Form 14 to alert the RCMP because he knew Mr. Bobbie well. He had a presumption that Mr. Bobbie was with his family and that he return back to SMHC as he routinely did. Because of this, Dr. Kremer did not feel this was a situation to call the police for assistance to have Mr. Bobbie return. He did not consider Mr. Bobbie to be at an increased risk of suicidal tendencies other than on a general chronic level. Risk of suicide was not a major factor in giving the verbal order to confine Mr. Bobbie. The motivation to confine him was to express that DBT was an important part of his treatment. Overall, the treatment team was supportive of Mr. Bobbie visiting his mother. The reason privileges were withheld was to underscore that he needed to abide by his treatment plan. The staff needed some ability to control the behaviour of patients and impose repercussions for ignoring the nurse's directions.

E. Perspective of the Family

[45] Mr. Bobbie's brother, Kevin Bobbie, testified at the inquest, as did Mr. Bobbie's daughter, Pharus Bobbie. Dealing with the loss of a loved one is always difficult and the family is thanked for their contribution to this inquest.

[46] Mr. Bobbie had been an involuntary resident at SMHC for 12 years and it is often the case that over such an extended period of time, differences of opinion regarding the manner of care will arise. The family expressed concerns about:

- the high levels of medication being prescribed to Mr. Bobbie;
- the monitoring of Mr. Bobbie's health;
- communication with the treatment team, and in particular, Dr. Kremer; and
- the granting of privileges.

[47] The scope of this inquest is limited to the circumstances relating to Mr. Bobbie's death and the practice of issuing passes to involuntary residents of mental health centres in Manitoba. As such, it is only the fourth area of concern expressed by the family which falls within the mandate of this inquest.

[48] On the issue of granting of privileges, Kevin Bobbie described a seemingly never ending cycle of Mr. Bobbie earning and losing his privileges. The problem was that if he did not comply with his medications and treatment, he would lose his privileges. Mr. Bobbie and his family did not always agree with the medication regime and there were times where he appeared overly sedated. Mr. Bobbie reported to his family that he had, at times, been held down by staff to be given an injection. Mr. Bobbie very much enjoyed going out on passes and staying with family. There were many occasions where he would go AWOL from SMHC so he could visit his mother. During those times, the family would be hesitant to call the hospital because that would result in loss of privileges.

[49] Pharus Bobbie expressed similar concerns that Mr. Bobbie required more time with family rather than more medication. She had tried to have her father released to her care, but that had not yet been put into place. Ms. Bobbie felt strongly that Mr. Bobbie's actions were not a suicide as he had so much to live for.

F. Perspective of the Treatment Team

[50] Key members of Mr. Bobbie's treatment team at SMHC testified at the hearing, including his treating psychiatrist, Dr. Kremer, on call psychiatrist Dr. Graham, his primary nurse Sarah Punzel, Unit 14 ward nurses, the community mental health program worker, his DBT clinical psychologist, and SMHC administrators.

[51] When asked whether they had any suggestions as to whether anything could have been done to prevent Mr. Bobbie's death or how things might have been done better, the responses included:

- Having the ability to lock Area 14 would give staff greater control of ingress and egress and allow staff to execute orders;

- Provision of visual aid equipment such as cameras would also better enable staff to execute orders;

- Staffing Area 14 with a security officer to monitor the door;

- Allow transfer of patients from Area 14 to Area 15 more readily;

- Improve staffing ratios by hiring more nurses and remove the task of answering phones from the nurses' responsibilities.

VI. SUMMARY OF CIRCUMSTANCES SURROUNDING RONALD BOBBIE'S DEATH

[52] Mr. Bobbie was a 12 year forensic resident at SMHC. He had originally been placed under the jurisdiction of the CRB after being found not criminally responsible on account of mental disorder. Mr. Bobbie suffered from rapid cycling bipolar disorder which manifested in patterns of alternating depressive and hypomanic episodes. When in the hypomanic phase, Mr. Bobbie was described as entitled, irritable, oppositional and grandiose. He would frequently leave SMHC on an AWOL basis and would be prone to impulsive behaviour.

[53] At the time of his death, Mr. Bobbie had made some progress in the control of his condition and had not re-engaged in any type of behaviour that led to his index offence. He was not considered a significant risk to himself or others so long as appropriate conditions were put in place to ensure continued compliance with prescribed psychiatric treatment and follow-up. The treatment team was working on plans for his reintegration into the community.

[54] Mr. Bobbie was AWOL from SMHC at the time of his death. He had been ordered confined to the unlocked ward in Area 14 and was directed to remain in his pajamas that day. By avoiding detection by the Area 14 nurses, Mr. Bobbie left the ward without permission. The AWOL protocol of issuing a Form #14 to enlist the assistance of RCMP had not been executed. Dr. Kremer in his discretion and based on his knowledge of Mr. Bobbie's patterns and history deemed it unnecessary. Instead, there was a verbal order in place that upon Mr. Bobbie's return, he was to be confined to the locked ward in Area 15 until he could be assessed by Dr. Kremer. Mr. Bobbie's pass privileges had not been revoked on account of immediate concern for the safety of himself or others. They had been revoked in order to secure compliance with medication and participation in DBT group therapy sessions, which was considered necessary for Mr. Bobbie's upcoming future goals of being reintegrated into the community.

[55] The known circumstances surrounding Mr. Bobbie's death by drowning do not explain how or why Mr. Bobbie ended up in the river. Eye witnesses saw Mr. Bobbie calling for help and struggling to stay above water. Discharge planning was underway and he was very future oriented at the time. He had good relationships with his family and enjoyed visiting them. These facts would suggest that his presence in the water was accidental. On the other hand, Mr. Bobbie's psychiatric condition made him at times prone to impulsivity and past instances of suicidal ideation involved themes of death by drowning in the river.

[56] In the end, no conclusions can be made as to how Mr. Bobbie came to be in the river that day.

VII. RECOMMENDATIONS

[57] The mandate of this inquest is to consider whether anything can be done to prevent similar deaths from occurring in the future. Inquest counsel described two main themes arising from the evidence heard at the inquest, and I agree with her characterization. First, there was the practice of issuing "extended passes." This refers to the practice which had developed with respect to the management of Mr. Bobbie's care where he would leave Area 14 without permission and his psychiatrists would exercise discretion in refraining from ordering the issuance of a Form 14 with the expectation that Mr. Bobbie would return to the ward by evening on his own accord.

[58] The second theme concerned patient monitoring and the ability of the Area 14 nursing staff to implement doctor's orders to confine a patient to the ward.

[59] During closing submissions, Inquest Counsel suggested the following recommendations:

1. With respect to the issuing of extended passes, the Crown was not advocating that Form 14 be mandated for each absence.

2. With respect to patient monitoring on SMHC Unit 14, the Crown had 5 recommendations:

    a. More frequent and more regular training sessions be held for all staff on SMHC policies and procedures, specifically in the area of unauthorized absences and passes;

    b. A policy should be created to ensure ease of patient transfer by nursing staff from Area 14 to SMHC's locked unit A15;

    c. Change of physical layout should occur which would make it easier for SMHC staff to see patient traffic through the exit and entrance doors. This could be effected by use of a pass card, magnetic card or buzzer system. Other suggestions would be to move the nursing station to provide better line of sight or placing a security desk or security personnel near the exit doors;

    d. SMHC should consider creation of a new position for telephones to be answered without hindering the nurses' ability to care for and monitor patients on the ward; and

    e. Staff to patient ratios should conform to industry standards.

[60] Counsel for SMHC confirmed that some of the recommendations related to patient monitoring have been or are in the process of being addressed. SMHC policies are reviewed

regularly and training sessions are held with staff. Policy C-40 dealing with transfer and discharge of forensic patients was recently amended to grant nursing staff the authority to transfer a forensic patient to A15 as a day guest without first requiring the order of a psychiatrist. These new provisions came into effect in April 2017. Renovations are planned to construct a security control room to service both Area 14 and 15 so that the entrance doors to Area 14 will be locked and patients will have to communicate with the security control room to unlock the door. Finally, with respect to staffing issues, SMHC has made requests for increased staff but must operate within the realities of available funding.

A. Issuing Passes

[61] The evidence of the healthcare professionals who testified at the inquest confirmed that the philosophy of care in mental health treatment is one which focuses on recovery. The goal is to grant autonomy where appropriate and grant greater responsibility and liberties where appropriate. The process of granting increased latitude is individualized, based on predictors of behaviour, and is a clinical decision based on input from an interdisciplinary team. This remains the case in the context of a forensic patient under the jurisdiction of the CRB. The only difference is that the parameters of the patient's privileges and passes are determined by the CRB.

[62] I accept that Mr. Bobbie's diagnosis and treatment needs were very unique and rapidly changing. His treatment team had to use their own clinical judgment on any particular day to assess whether or not it was appropriate for Mr. Bobbie to be granted a pass. The treatment team, and in particular, Dr. Kremer or the on-call psychiatrist, would have to exercise discretion and clinical judgment as to whether a Form #14 should be issued on the occasions where Mr. Bobbie left AWOL without being granted pass privileges. At the inquest, we heard evidence regarding the various factors which would be considered in making the decision. These factors would be unique and individual to the patient in any particular case. I do not find that there is a need to recommend any universal policy or approach with respect to the practice of issuing passes to involuntary residents of mental health centres in Manitoba. In particular, I do not find that it is necessary or advisable to recommend mandatory issuance of Form #14 in all cases where an involuntary patient is AWOL.

[63] In Mr. Bobbie's case, he was not considered a risk or threat to the safety of himself or others when he was AWOL. In fact, the only reason why his privileges were being reduced was in an attempt to control his behaviour, rather than concern about safety. There was no indication that he was suicidal at the time.

[64] The family's frustration with the withholding of privileges for the purposes of controlling behaviour is certainly understandable, but I view this as a necessary aspect of his treatment plan. Mr. Bobbie's recovery was dependent on his compliance with medication and treatment. His refusal to cooperate and participate with his treatment left his team with limited options to secure compliance. The expectation, of course, is that decisions will be made clinically and professionally and that privileges will not be withheld arbitrarily and without good cause. The evidence heard at the inquest gave no indication that any inappropriate decisions were being made at the time of Mr. Bobbie's death. The withholding of Mr. Bobbie's pass privileges was

directly related to his continued refusal to participate in DBT, which was considered necessary for his successful reintegration into the community.

[65] Overall, I find that it is not necessary to make any recommendations regarding the practice of issuing passes to involuntary residents of mental health centres in Manitoba.

B. Patient Monitoring

[66] At the time of his death, Mr. Bobbie was under orders to be confined to the ward. He surreptitiously left Area 14 at a time when he could escape detection by the ward nurses. This was not difficult for him to achieve.

[67] At the inquest, the nurses described the tools which they had in order to execute a doctor's orders to confine a patient to the ward. They would ask the patient for compliance with the order and may request that the patient remain clothed in brightly coloured pajamas which would make it obvious that they were not to be out on the street. The nurses could also institute quarterly observations every 15 minutes, but this would be in addition to other tasks which had to be completed by the nurses during their shifts.

[68] Overall, the controls were largely based on trust. If the patient refused or was unwilling to comply, the ultimate result would be that a doctor's order would be sought to have the patient placed on the locked Area 15. This was exactly what would have happened to Mr. Bobbie had he returned back to SMHC that evening.

[69] The layout of Area 14 is such that the nursing station and nursing desk do not have direct sight lines to the entrance doors. The doors are unlocked during the day and there is no camera or other system of monitoring.

[70] It is questionable whether any changes to patient monitoring would have prevented Mr. Bobbie's death. As noted earlier, he was not considered a suicide risk and the reason for withholding of privileges was disciplinary rather than based on safety. However it is clear that equipping the nurses with better tools to execute doctor's orders would be beneficial to the delivery of mental health treatment in Area 14. It would appear that SMHC has already made some changes in that regard. The revisions to Policy C-40 mentioned earlier authorize nursing staff to transfer a forensic patient to A15 without first requiring the order of a psychiatrist.

[71] Steps have been taken to construct a security control room to monitor and control entry and exit to Area 14. Testimony at the inquest indicated that creating a locked environment on Area 14 is a balancing exercise, with the desire to create greater patient autonomy on the one hand, and maintaining control of behaviour on the other. I will not make any specific recommendations regarding the type of changes to be made, but I do support the general recommendation that Area 14 nursing staff should be better able to monitor patient ingress to and egress from the ward. This may take the form of physical changes to the ward, or increased staff ratios to meet industry standards, or both.

[72] Finally, with respect to the suggestion that there be more frequent training sessions for staff, it was acknowledged by SMHC that continuing review and knowledge is necessary but it was submitted that there was no evidence that any staff did not understand policy or were not properly trained in a way that had bearing on Mr. Bobbie's death. I agree and it is not necessary to make any recommendation in this regard.

[73] Accordingly, after reviewing the circumstances relating to Mr. Bobbie's death, I make the following recommendation:

1. With respect to patient monitoring on SMHC Area 14, nursing staff should be equipped to enable effective monitoring of patient ingress and egress. This may be implemented by physical changes to the ward or staffing changes or both.

I respectfully conclude and submit this Report on this 13th day of June 2017, at the City of Winnipeg, in the Province of Manitoba.

"*Original signed by Judge Lindy Choy*"

Judge Lindy Choy

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: RONALD BOBBIE

APPENDIX A – EXHIBIT LIST

Description

1. Letter from Chief Medical Examiner dated June 26, 2015

2. Two binders of material consisting of:

   Tab 1: Documents relating to Mr. Bobbie's death
   Tab 2: Documents relating to Mr. Bobbie's care from January to September, 2014
   Tab 3: Documents relating to incident between June 15 and June 30, 2014
   Tab 4: Documents relating to incident between September 15 and 31, 2011
   Tab 5: CCRB materials

3. Can-say statement of Barbara Mondor

4. Report of Fire Chief, Donald Enns

5. Resuscitation report authored by Dr. A. Buchel

6. Coil book of material containing documents relating to Behavioural Program, Diagnostic Reports, Physician Orders and Recovery Planning Meeting Notes.

7. Curriculum vitae of Dr. Steven Kremer

8. Diagram of the Barnett Building at the Selkirk Mental Health Centre

9. Progress notes report regarding Ronald Bobbie dated December 15, 2011

10. Patient progress report regarding Ronald Bobbie

11. Curriculum vitae of Dr. Murray Enns

12. Marked diagram of Exhibit 8

13. Curriculum vitae of Dr. Roger Craig Graham

14. SMHC Program Policy Manual – C-10: Principles of Recovery Planning policy (August 2016)

15. Curriculum vitae of Kristen L. Young

16. SMHC Program Policy Manual – C-40: Transfer/Discharge of Forensic Patients (April 2017)

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: RONALD BOBBIE

APPENDIX B – INQUEST WITNESSES

- First Responders
  - Chief Donald Enns
  - Captain Gary Oakley
  - Ryan Vanderzwan
  - Cst. Evan Scott-Herridge

- Family members
  - Kevin Bobbie
  - Pharus Bobbie

- Dr. Steven Kremer, treating psychiatrist

- Dr. Murray Enns

- SMHC Treatment Team
  - Carlos Jiminez
  - Dennis Tucker
  - Sarah Punzal
  - Lee Procyk
  - Curtis Chartrand
  - Dr. Roger Graham
  - Vernon Yaskiw
  - Dr. Kristin Young

- SMHC Administrative Team
  - Robyn Cromarty
  - Marsha Curtis