Release Date: April 13, 2016

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT*** **C.C.S.M.C. F52**

AND IN THE MATTER OF: An Inquest into the death of:

CRAIG KUCHER
(DATE OF DEATH: June 18, 2012)

Report on Inquest and Recommendations of
Judge Donovan Dvorak
Issued this 7th day of April, 2016

APPEARANCES:

MR. RONALD TOEWS AND MS. MARNIE EVANS, Inquest Counsel
MR. RICK KUCHER AND MS. SHARON KUCHER, Parents of Craig Kucher
MR. DAVID SWAYZE, Counsel for the Prairie Mountain Regional Health Authority and Dr. Mano Vipulananthan
MR. JIM KOCH, Justice Manitoba, Legal Services Branch on behalf of Manitoba Corrections

M A N I T O B A

THE FATALITY INQUIRIES ACT, C.C.S.M. C F52
REPORTED BY PROVINCIAL JUDGE ON AN INQUEST
RESPECTING THE DEATH OF CRAIG KUCHER

Having held an Inquest respecting the death of CRAIG KUCHER on October 5, 6 and 7, 2015, at the City of Brandon, in Manitoba, I report as follows:

The name of the deceased is: CRAIG KUCHER

CRAIG KUCHER came to his death on the June 18, 2012, at the City of Brandon, in the Province of Manitoba.

The cause of death was blunt force injuries with complete transection above the pelvis as a consequence of a train accident.

I hereby make the recommendations as set out in the attached report.

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

Dated at the City of Brandon, in Manitoba, this 7th day of April, 2016.

Original signed by:
"original signed Judge Dvorak"
Donovan Dvorak
Provincial Court Judge

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4) Ms. Julie Frederickson, Deputy Minister of Justice and Deputy Attorney General
5) Mr. Michael Mahon, Assistant Deputy Attorney General, Prosecutions Division, Manitoba Justice
6) Mr. Ronald Toews, Inquest Counsel
7) Ms. Marnie Evans, Inquest Counsel
8) Mr. Rick Kucher, parent of Craig Kucher
9) Ms. Sharon Kucher, parent of Craig Kucher
10) Mr. David Swayze, counsel for the Prairie Mountain Regional Health Authority and Dr. Mano Vipulananthan
11) Mr. Jim Koch, Justice Manitoba, Legal Services Branch on behalf of Manitoba Corrections
12) Mr. Robert Patterson, counsel for The City of Brandon and Brandon Police Service
13) Lorraine Prefontaine, Director of Special Prosecutions and Appeals
14) Exhibit Officer
15) Ms Aimee Fortier, Executive Assistant and Media Representative, Provincial Court of Manitoba

II MANDATE AND CHRONOLOGY OF THE PROCEEDINGS

1. On December 13, 2013, Dr. Thambirajah Balachandra, Chief Medical Examiner for the Province of Manitoba, directed that an inquest be held into the death of Craig Kucher for the reasons set out in his letter to Chief Judge Ken Champagne:

    1) To fulfil the requirement for an inquest as defined in Section 19(3)(a) of *The Fatality Inquiries Act;*
    2) To determine the circumstances relating to Mr. Kucher's death, including the appropriateness of his medical management, which included a leave of absence from the facility while he was still an involuntary patient at the Centre for Adult Psychiatry; and
    3) To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

2. Section 19(3) of the *Act* states:

    Where, as a result of an investigation, there are reasonable grounds to believe

    (a) that a person while a 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 a 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.

3. Although Mr. Kucher was residing at his parents' home at the time of his death, he had not been discharged from the Centre for Adult Psychiatry, having been given a two-day leave of absence. As such he remained an involuntary resident of a psychiatric facility.

4. Mr. Ronald Toews and Ms. Marnie Evans were appointed Inquest Counsel. Prior to the hearing, standing was granted pursuant to section 28(1) of the *Act* to:

Mr. Rick Kucher and Ms. Sharon Kucher, the parents of Craig Kucher,
Mr. Robert Patterson, counsel for The City of Brandon and Brandon Police Service,
Mr. David Swayze, counsel for the Prairie Mountain Regional Health Authority and Dr. Mano Vipulanathan, and
Mr. Jim Koch, Justice Manitoba, Legal Services Branch, on behalf of Manitoba Corrections.

5. The inquest proceeded October 5 to 7, 2015 in Brandon. The following witnesses testified at the inquest:

Mr. Rick Kucher
Ms. Sharon Kucher
Ms. Diana Kokorudz, Patient Safety Coordinator for Prairie Mountain Health
Dr. Stacey Kitz, Emergency Department Physician
Dr. Gilbert Lee, On-call Psychiatrist
Dr. Mano Vipulananthan, Staff Psychiatrist with the Centre for Adult Psychiatry
Mr. Steven Berry, Correctional Officer at Headingley Correctional Centre
Ms. Liliana Rodriguez, Director of Information Resources for Prairie Mountain Health

III MATERIAL CIRCUMSTANCES

6. At 9:17 PM on June 18, 2012, Brandon Police Service received a report that "a child had been struck by a train in the 1000 block of Pacific Avenue". When police arrived at the

scene they located an adult male body near the 1st Street Bridge. Based on the photo driver's license found in the deceased's wallet, he was identified as Craig Kucher. It was determined that Mr. Kucher had been transected by the wheels of the train, having fallen between the first and second rail car. There was no evidence of foul play.

7. An autopsy was done on June 19, 2012 at the Brandon Regional Health Centre. The cause of death was determined to be blunt force injuries with complete transection above the pelvis as a consequence of a train accident. Delusional disorder was listed as a significant condition contributing to the death but not causally related to the immediate cause. It could not be determined whether the death was a suicide or an accident.

8. On June 7, 2012, eleven days prior to his death, Mr. Kucher had presented at the Emergency Department of the Brandon Regional Health Centre with the delusion that he had a device implanted in his foot. Dr. Stacey Kitz, the physician at the Emergency Department, assessed Mr. Kucher and completed an Application by Physician for Involuntary Psychiatric Assessment pursuant to *The Mental Heath Act*. Initially Mr. Kucher agreed to go for the assessment, but subsequently changed his mind and barricaded himself in a room and turned off the lights. The police attended and were able to de-escalate the situation and get Mr. Kucher to the Centre for Adult Psychiatry (CAP).

9. Dr. Gilbert Lee, the on-call psychiatrist, saw Mr. Kucher on June 8, 2012. Dr. Lee determined that Mr. Kucher was suffering from an acute delusion, that he should be involuntarily admitted and that he was not in a position to make treatment decisions. Mr. Kucher was treated as an involuntary in-patient at CAP.

10. Mr. Kucher's condition improved to the point that on June 18, 2012, staff psychiatrist Dr. Mano Vipulananthan was prepared to release Mr. Kucher to the care of his mother for a two day leave of absence. Dr. Vipulananthan met with Mr. Kucher and his mother Sharon Kucher at approximately 3:00 PM in the afternoon of June 18, 2012. They discussed where he was going to stay and the medications he was to take. Mr. Kucher was given pills to take home with him along with instructions to attend employment and income

assistance as well as mental health services the next day to assist with obtaining his medications. Although Dr. Vipulananthan had previously informed Mr. Kucher of the possible effect of consuming alcohol or using illicit drugs while on his medication, she did not inform Ms. Kucher of this concern at their meeting.

11. Following Mr. Kucher's release from CAP, he and his mother went to Mr. Kucher's parents' home as that is where he was to stay during the leave. At approximately 6:00 PM on June 18, 2012 Mr. Kucher told his mother that he was going out for a while and that he would see her in just a little bit. His sisters had asked him to meet them at the Crystal Hotel Bar which is down the railway tracks from the Kucher home. Mr. Kucher was not displaying signs of distress or depression, and did not make any threats of self-harm. Ms. Kucher last saw her son leaving the home carrying his backpack.

12. Craig Kucher had a history of mental health issues that began as an adolescent. Craig's parents, Rick and Sharon Kucher, testified that Craig was born September 5, 1987 in Minnedosa, Manitoba. Craig was the oldest of their four children and their only son. Craig faced many challenges growing up. He had a difficult time relating to other children, difficulties that at times would lead to fights or other problem behaviours.

13. Craig's first contact with mental health services was following a house fire in Victoria, British Columbia when he was three years old.

14. Once he was of school age, Craig had difficulty managing his behaviour in a classroom setting. He could not stay still and exhibited other challenging behaviours. Craig was tested not long after he began school and it was determined that he suffered from attention deficit disorder and obsessive compulsive disorder.

15. Craig's first contact with the Child and Adolescent Treatment Centre (CATC) in Brandon was in October of 1999, with Craig being admitted between October 21 and November 25, 1999. Ms. Kucher testified that prior to his admission, Craig was talking about aliens in his room and that he didn't want to be outside for more than 10 minutes as the aliens

would get him. The medical reports from Craig's time at CATC make reference to this delusion, along with his demanding and defiant behaviour.

16. Craig returned to CATC on October 16, 2001 due to increasingly challenging behavioural issues at home and at school. He was discharged to his parents on December 6, 2001. He was also admitted to CATC from November 19, 2002 to January 27, 2003 and from March 13 to 17, 2003. As an adult, he was a voluntary impatient at CAP from December 15 to 21, 2007.

17. Mr. Kucher was the subject of a psychiatric assessment in relation to a number of criminal charges from the summer of 2011. Dr. Frank Vattheuer's psychiatric report, dated August 11, 2011, stated that Mr. Kucher was fit to stand trial and was not suffering from a mental illness such that he would be exempt from criminal responsibility.

18. Mr. Kucher was incarcerated for a nine month period at the Headingley and Brandon correctional facilities. He was released on June 2, 2012, five days prior to his admission to CAP.

IV ANALYSIS AND CONCLUSIONS

19. A number of the material circumstances, including Mr. Kucher's prior use of trains for transportation, his position in relation to the train when he was struck, and a lack of evidence of an intention to harm himself are suggestive of an accident rather than suicide. However, suicide cannot be ruled out as a possible explanation for Mr. Kucher's death. Although delusional disorder was listed in the autopsy report as a significant condition contributing to the death of Mr. Kucher, the evidence before the inquest was clear that he was no longer suffering from a delusion at the time of his death.

20. The leave of absence provided to Mr. Kucher on June 18, 2012 was appropriate and medically justified. Mr. Kucher's condition had improved significantly. He was no longer suffering from the delusion that grounded his involuntary admission. He was compliant

with taking his medication. His parents were prepared to take him into their care. There was nothing to suggest that he might harm himself or anyone else. I find that there was no demonstrated causal connection between the care that Mr. Kucher received at the Centre for Adult Psychiatry and his death.

21. Counsel for the Regional Health Authority and counsel for Corrections take the position that it should follow from the above noted finding that I do not have the jurisdiction to make recommendations. I do not share that view.

22. Section 33(1) of *The Fatality Inquiries Act* states that the presiding judge

> ". . . may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest."

23. I do not see this section as limiting an inquest judge's jurisdiction to make recommendations to only those circumstances that had a direct causal connection to the death that is the subject of the inquest. An inquest judge is entitled to consider circumstances leading to the death that, though not causally connected to the death, disclose a foreseeable issue that might lead to death under similar circumstances.

24. That being said, the provision is not so broad as to permit recommendations that are not supported by the evidence or are unrelated to the circumstances surrounding the person's death.

25. Inquest Counsel and Mr. Kucher's parents have asked that I consider a recommendation as regards the provision of information to the parties who would be taking a patient into their care on a temporary leave.

26. Dr. Vipulananthan, the releasing psychiatrist, and Sharon Kucher, Craig Kucher's mother, both testified about the information provided as to Mr. Kucher's care when he was released to Ms. Kucher on temporary leave. Ms. Kucher was not told whether Mr. Kucher could be out in the public unsupervised, whether he could mix alcohol with his medication, what signs to look for that should cause her concern, or what she should do if Mr. Kucher failed or refused to comply with his treatment.

27. There was no evidence before the inquest that there is a policy in place at the Centre for Adult Psychiatry that directs the discharging psychiatrist to provide information regarding the patient's care to the person into whose care a psychiatric patient is placed for a temporary leave. Although it is not possible to know whether that may have had a causal connection to Mr. Kucher's death, it is reasonable to believe that failure to provide such information to the caregiver as regards a patient on a temporary leave could lead to death under similar circumstances.

28. Although the release of this care information might cause concerns as regards the privacy of the patient's personal medical information, it could be provided without the patient's consent pursuant to section 36(2)(c) of *The Mental Health Act*, which states:

> The medical director of a facility in which a clinical record is maintained may disclose information in the record without the patient's consent or consent on the patient's behalf under subsection (1), if the disclosure is . . .
>
> > (c) to a person who is providing health care to the patient, to the extent necessary to provide that care, unless the patient, while competent, has instructed the medical director not to make the disclosure

29. If that provision does not apply, the temporary leave could be made conditional on the patient consenting to the release of that information on the grounds that it would be required for the patient's proper care in the community.

30. Inquest Counsel and Mr. Kucher's parents also expressed concerns about the capacity to share medical information between and within medical facilities.

31. Witnesses at the inquest testified as to the procedure of accessing some forms of medical information by calling or writing to other medical facilities to ask them to send out their paper medical file. It was explained that some medical records remain in paper form and that different facilities store their electronic information in different forms using different programs.

32. There is little doubt that having digitally stored psychiatric files that are accessible by computer in any regional health centre in the province would assist in ensuring that a patient receives timely care from medical professionals who are fully aware of the patient's psychiatric history. However, there is no evidence before the inquest that would suggest that barriers to access played any role in Mr. Kucher's death or that removing those barriers would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in Mr. Kucher's death.

V. RECOMMENDATIONS

1. Ensure that clear protocols are in place at all mental health facilities that would direct the authorizing physician to ensure that the person or persons taking responsibility for a patient to be released on a temporary leave understand what is expected of them by way of supervision of the patient, any potential signs of illness relapse, medication dosage and administration, and any potential contra-indications between the prescribed medications and illicit drugs and/or alcohol.

2. Ensure that clear protocols are in place at all mental health facilities that would direct the authorizing physician to ensure that the patient to be released on a temporary leave is aware of the physician's expectations as regards the patient's cooperation with treatment and supervision, medication dosage and administration, the possible impact of the use of illicit drugs and/or alcohol and the circumstances which would necessitate their return to the mental health facility prior to the end of the leave.

3. Written copies of that information should also be provided to the patient and the person or persons taking the patient into their care.

Dated at the City of Brandon, in Manitoba, this 7th day of April, 2016.

"original signed by Judge Dvorak"
Donovan Dvorak
Provincial Court Judge

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VI. EXHIBIT LIST

Exhibit #1	Physicians History Sheet by Dr. Mano Vipulananthan
Exhibit #2	Documents for the Inquest of Craig Kucher filed by Manitoba Justice, Prosecution Services, Mr. R. Toews and Ms. M. Evans