Release Date: March 6, 2006

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **MS ANNA MACIOCHA, Deceased**

APPEARANCES:

Inquest Counsel:	Ms Terry McComb
Inquest Coordinator:	Ms Betty Owen
For Drs. Eunice Gill, Kenneth Zimmer, Nadia Tomy and Hayley Menzies:	Mr. Tyler J. Kochanski
For the Health Sciences Centre:	Mr. Sarantos Mattheos, assisted by Ms Marcia Dzik
For the Maciocha Family:	Ms Yvonne Pregely, step-sister of the late Ms Anna Maciocha

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HOLDING OF INQUEST

[1] Ms Anna Maciocha was a 27 year old woman who committed suicide on April 5, 2004 while an involuntary patient on PY2, a ward at the PsycHealth Unit, Health Sciences Centre, in Winnipeg. She had been committed to the ward on February 9, 2004 on an involuntary basis as a result of a psychiatric assessment. It was thought she was in a manic phase of bipolar affective disorder. On the morning of her death at 11:00 a.m. Ms Maciocha left the ward by signing herself out on a two-hour unaccompanied pass. At approximately 1:45 p.m. the Medical Examiner's Office contacted the ward and advised that Ms Maciocha had committed suicide.

[2] As a result, on November 8, 2004 the Chief Medical Examiner of the Province of Manitoba called for an inquest to be held, pursuant to section 19(2) of *The Fatality Inquiries Act*, for the following reasons:

1. to fulfil the requirement for a mandatory inquest as defined in Section 19(3)(a)of the Legislation;

2. to determine the circumstances under which the death occurred; and,

3. to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[3] The Inquest sat on the following dates: Thursday, October 6, 2005; Friday, October 7, 2005; Tuesday, October 11, 2005; Wednesday, October 12, 2005; Friday, October 14, 2005; Wednesday, October 19, 2005; Thursday, October 20, 2005; Monday, November 21, 2005; Tuesday, November 22, 2005; Wednesday, November 23, 2005; and Thursday, December 15, 2005.

[4] In total, the Maciocha Inquest sat for 11 days; there were no witnesses on three of those days and the Court sat briefly. Fourteen witnesses were called before the Court. Counsel were invited to make written or verbal recommendations to the Court. Both the Crown and counsel for the Health Sciences Centre submitted written recommendations.

[5] Transcripts have been prepared of the entire proceeding and are available electronically from Transcription Services. A Chronology of Key Events has been prepared by the Inquest Coordinator and is attached to this report.

ACKNOWLEDGMENTS

[6] The Court wishes to acknowledge the time and efforts of the Inquest counsel, Terry McComb, and the Inquest Coordinator, Betty Owen. Their fine work greatly assisted the Inquest in identifying the issues and ensuring that the appropriate witnesses were called upon to testify. The organization and preparation of the materials and exhibits by Ms Owen expedited the hearing for all concerned. The Court also appreciates the contributions and patience of counsel who were involved representing various parties, specifically Mr. Kochanski, Mr. Mattheos, and Ms Dzik.

[7] The Court was assisted in the preparation of this report and its recommendations by a committee of representatives from the Health Sciences Centre who took the time to meet and suggest recommendations to address the concerns raised by the evidence. The Court wishes to thank these individuals for providing their input. The committee was comprised of:

- Dr. Perry Gray, Vice-President and Chief Medical Officer, Health Sciences Centre;
- Dr. Samia Barakat, Clinical Head, Mental Health Program, Health Sciences Centre;
- Dr. Patricia Wightman, Assistant Head, Mental Health Program, Health Sciences Centre;
- Dr. Stanley Yaren, Deputy Head, Mental Health Program, Health Sciences Centre, and Medical Program Director, Forensic Psychiatry, Health Sciences Centre; and
- Mr. Patrick Griffith, Director of Patient Services, Adult Mental Health Program, Health Sciences Centre.

[8] It is acknowledged (in accordance with the committee's request) that because of time limitations on the committee, their recommendations were not subjected to the same level of review and scrutiny that would usually take place through the hospital organization and that further review of these recommendations will be necessary upon receipt of this report. Having said that, the input of the committee was helpful to the Court. In many cases, the Court was able to incorporate the recommendations of the committee in their entirety or with little

change. Hopefully the input of this committee will result in the implementation of recommendations that will be helpful, practical and informed.

[9] The Court acknowledges with gratitude the contributions of Ms Maciocha's family to the inquest process and extends sincere condolences to them for their loss.

INTRODUCTION

[10] The evidence that was called at the Inquest raised a number of issues and concerns for the Court to consider. Some of these issues were specifically articulated by the witnesses; others were inferred by the Court as a result of the evidence called. Although many issues were raised throughout the evidence, the scope of this report is limited to those issues and circumstances that are in some way relevant to the death of Ms Maciocha, that either may have contributed to her death or may assist in the prevention of similar deaths in the future.

[11] I have grouped these diverse issues into a number of general categories. What follows is a summary of the evidentiary foundations that gave rise to each concern and a discussion of the issues arising from the evidence and the resulting recommendations that flow from each of the concerns.

COMMUNICATION WITH THE FAMILY

Evidence

[12] The Court had the benefit of the presence of Ms Maciocha's sisters, Yvonne Pregely and Dorota Wisniewski, throughout the entire Inquest. Ms Wisniewski provided evidence at the Inquest and Ms Pregely played a role in the proceedings by questioning witnesses and commenting on behalf of the family on occasion.

[13] It was clear from the testimony of Ms Wisniewski that the family felt "out of the information loop" when it came to Ms Maciocha's care. The family often felt that they were imposing on medical staff when they made inquiries about Ms Maciocha and felt powerless to press their concerns and questions. The family feared that attempts on their part to pursue information about Ms Maciocha from nursing staff might impact negatively on Ms Maciocha's care.

[14] When the family met in person with Dr. Eunice Gill, Ms Maciocha was present and in a manic state so the conversation was very interrupted. The family had no communication at all with Dr. Kenneth Zimmer, Ms Maciocha's attending physician when Dr. Gill was away on holidays. The family was not advised

beforehand when Ms Maciocha was about to receive weekend passes and did not receive any instructions about appropriate care for Ms Maciocha when she was out on escorted passes. For example, they were not advised about Ms Maciocha's medication needs and received no instruction about what to do if Ms Maciocha's condition worsened while out on a pass. The Court was advised that there is no policy in place for providing families of patients with information regarding passes or for receipt of information from the family upon the patient's return.

[15] On this point, the night before Ms Maciocha's death, her sister, Ms Wisniewski, brought her back early from a weekend pass as she was concerned about Ms Maciocha's deteriorating condition. She urged staff to revoke Ms Maciocha's passes, as she feared for Ms Maciocha's safety and that she would harm herself. This critical feedback from family resulted in no formal action by staff. Her primary nurse took no action to revoke Ms Maciocha's passes that night. This failure to revoke Ms Maciocha's passes will remain an issue that will be discussed at greater length throughout this report.

Issues

[16] It remains unclear from the evidence how a family is best able to exchange information with the medical team. Some very general informational materials are available on the ward for families, although the Maciocha family was never given these materials.

[17] In many cases, the family is a valuable source of information about the patient's condition, especially if, as in this case, the patient was an involuntary patient. The family's input into Ms Maciocha's care was critical for obvious reasons. Consent for her treatment was provided by Ms Wisniewski. Despite the obvious need for communication with the family in a situation like this, the health care professionals who testified appeared unsure how much information about the patient could be shared with family members.

[18] In Ms Maciocha's case, her attending physician went on holidays and her primary nurse changed often. It appears that the Maciocha family was not made aware of these staff changes so they were often unaware of who best to speak to about Ms Maciocha's progress.

[19] Dr. Zimmer was unsure in his testimony as to whether he could even tell Ms Maciocha's family that he was Ms Maciocha's attending psychiatrist while Dr. Gill was away on holidays. Failure to share such fundamental information results in an untenable situation. Given that Ms Maciocha was an involuntary

patient the entire time that she was in the hospital, it is unclear why the medical professionals involved in her care would feel unable to discuss Ms Maciocha's treatment with her sister who was, in fact, the relative providing the consent for Ms Maciocha's treatment.

[20] The last, and perhaps most distressing, example of the failure to ensure appropriate communication with the family occurs at the time of Ms Maciocha's death. Despite existing hospital policy requiring the attending physician or resident to notify the next of kin of a patient's death (Exhibit 2, C11), no physician initiated contact with Ms Wisniewski to inform her of her sister's suicide. Instead, the police were apparently dispatched to Ms Maciocha's father's residence. Even after Ms Wisniewski phoned the ward and learned unexpectedly of her sister's suicide, it appears no one from the medical team attempted to call her back to see if she required assistance when she became overwhelmed and had to hang up.

Recommendations

1. Information flow to the families of patients must be improved and the ability of the family to voice their concerns to the caregivers must be improved. The family needs to be given more information about how they can participate in the care of their relative and how to communicate their concerns to the caregivers.

2. The Mental Health Program should emphasize the importance of involving the patient's family members in the treatment provided to the patient, recognizing that in some cases this may not be appropriate.

3. Early in the admission process, inquiries should be made by the appropriate health care provider to determine the patient's wishes respecting disclosure of personal health information to family members. Personal health information may be disclosed, if clinically appropriate, in accordance with the patient's consent and privacy legislation.

4. Upon admission, the patient's noted contact or next of kin should be provided with The Family Orientation Pamphlet. The current pamphlet (Exhibit 7) does not go far enough. The pamphlet should be revised to include a personalized page for each patient that identifies the patient's primary and secondary nurses, the medical student and the resident involved and the attending physician and patient advocate, along with information about the best way to contact these individuals. If the patient has instructed that their family is not to receive information, that information should be

documented on this page. The provision of this material should be documented on the patient's chart.

5. If appropriate and if the patient consents in advance, within a short period of time from the patient's admission, the appropriate health care provider will schedule a family meeting.

6. During the family meeting or other interactions with the patient's family, family members should be encouraged to provide information about the patient to the treatment team on an ongoing basis and, in particular, to communicate any perceived changes in behavior or any other concerns.

7. If the patient has consented to the disclosure of personal health information prior to the family meeting, and if clinically appropriate, the treatment team may disclose personal health information and discuss the current treatment plan in accordance with the consent given by the patient.

8. Early in the admission process the treatment team should advise family members that passes may be granted to the patient and provide basic information to the family about passes.

9. The Family Orientation Pamphlet (Exhibit 7, Tab 6) should be revised to include a section dealing with passes which will set out basic information about the purpose of passes and encouraging family members to discuss any concerns respecting passes.

10. The patient's attending physician should inform the family of the patient's death as soon as it is practically possible to do so. At that time, the attending physician should offer to meet with the family within a reasonable period of time to discuss the circumstances leading up to the suicide.

11. The Bereavement Consultant at the Health Sciences Centre should follow up with the family of the patient within a reasonable period of time following the death to determine whether the family has any outstanding issues with respect to the suicide and, in particular, whether the family has met with the patient's attending physician to discuss the circumstances.

12. The legislative limitations that are placed on medical staff need to be better understood by the health care professionals. An educational workshop should be provided to the medical team and staff educating them about the privacy legislation and how it impacts on communication with families.

GRANTING OR REVOKING PASSES

Evidence

[21] The Court heard evidence from Dr. Stanley Yaren and Dr. Eunice Gill that passes are critical in helping restore the patient to full autonomy. The decision to grant or revoke a pass is a matter of clinical judgment for the health care professionals. The exercise involves a risk-benefit analysis by the treating psychiatrist and the rest of the medical team. Through the process of granting passes the involuntary patient is empowered and trusted to take increasing levels of greater responsibility for his or her own personal safety.

[22] The psychiatrists that testified stressed that patients are encouraged to regain autonomy. The role of passes is important to assist patients in their recovery and return to their base line. It is difficult and potentially dangerous to release patients abruptly back into the community. Passes play a pivotal role in the patient's recovery, allowing the patient to try out the improvements that have been gained while hospitalized. At the same time, the medical team may need the opportunity to test how the patient does in the community. The family can also get a realistic sense of the progress the patient may be making. As Dr. Yaren outlined, the process involves a risk-benefit analysis to be performed by the caregivers based on their professional experience and clinical judgment.

[23] Ms Maciocha's pass privileges were increased to a full weekend pass with no accompaniment the weekend before her death. This change was ordered by the second year resident. She had not been assessed by an attending psychiatrist since Dr. Gill left on holidays. This increase to her pass privileges is somewhat difficult to understand given that her condition had been deteriorating before she left on this 48-hour pass. Ms Maciocha's deterioration continued dramatically over the weekend. As indicated earlier, her sister brought her back to the ward, worried about her condition. Amongst other disturbing symptoms, Ms Maciocha sounded delusional, speaking about angels and heaven and had reported seeing ghosts in her apartment. Ms Wisniewski urged that her sister not be given any more passes, stating that she had never seen her sister "as bad".

[24] The Court was told that nurses have the authority to revoke passes and to change observation levels. When unsure, there is always a resident and attending physician on call for the nurses to consult. Ms Maciocha's primary nurse that evening, Nurse Panchi Latour, met with Ms Maciocha, but after talking with her, concluded that she was safe. Nurse Latour based this belief on Ms Maciocha's Roman Catholicism and her belief that Ms Maciocha was "contracting for safety".

Thus, despite the concerning behaviours and the authority to do so, Ms Maciocha's passes were not revoked by her primary nurse and no consultation with a doctor or resident was sought regarding Ms Maciocha's decompensated state.

[25] It was troubling to the Court that the other nurse who testified regarding the evening of April 4, 2004, Michelle Thorsteinson, stated that she believed that Ms Maciocha had been restricted to the ward that evening as a result of the deterioration in her condition. In actual fact, whatever assessment regarding Ms Maciocha's passes occurred that evening, there was no formal revocation of passes. There was no indication on the chart that Ms Maciocha's passes had been revoked and her status had not been changed. This is an important point. If these witnesses had been asked to make detailed notes immediately after Ms Maciocha's death, when their memories were clear, the Court could have had precise evidence on this critical point. Instead, the Court is hampered by somewhat contradictory evidence from these two health care professionals. This issue will be looked at again in the critical occurrence procedures discussion.

[26] The evidence from the nurses disclosed confusion amongst some of them as to the extent of assessment required before and after a pass. One nurse initially testified that no assessment was required. When the protocol was pointed out to her, she stated that the assessment procedure was superficial and, on her part at least, involved the making of small talk.

[27] Lastly, even though staff had requested that Dr. Gill see Ms Maciocha on the morning of her death because of her deterioration, no one asked Ms Maciocha to remain on the ward at least until Dr. Gill could reassess her and ensure that she was safe and that her observation level did not require change.

Issues

[28] The Court has been asked to not diminish the importance of the current collaborative practice involved in granting passes. The committee indicates that it would be impossible to craft a recommendation regarding passes that would not ultimately be dependent on clinical judgment. This cautionary note is fair. However, that does not mean that recommendations cannot be made that would prove helpful.

[29] There is a protocol already in place (Exhibit 2, C13) requiring that patients be checked before they leave on a pass and again when they return. Presumably this is to identify patients who should not be leaving the ward because of changes to their condition, despite the fact that a pass may have been previously granted.

A patient who is subject to rapid cycling (like Ms Maciocha) particularly needs to be assessed before leaving on a pass, as their condition can change rapidly.

[30] Patients who are returning from a pass also require a review. Patients need to be checked to ensure that they took their medications while out on a pass. Most importantly, patients need to be assessed to identify patients who have deteriorated while out on a pass and need to have their status changed.

[31] Dr. Yaren and Dr. Gill both testified that passes can be an important assessment tool to help family and staff determine how a patient is doing. In Ms Maciocha's case, the vital feedback from the family as a result of the weekend pass was disregarded and not acted upon.

Recommendations

1. When the attending physician has been asked to see a patient because of a deterioration in the patient's condition, the patient's passes should be temporarily revoked and the patient should not be allowed to leave the ward until after the examination by the attending physician.

2. After returning from a pass that involves a family member, the unit staff should attempt to obtain information from that family member regarding the pass and the patient's behaviour on the pass and, based on the clinical importance of the information conveyed by the family, such information should be both charted appropriately and relayed to the appropriate physician.

3. If a family member or patient caregiver requests that an involuntary patient's passes be revoked because of a suicide risk or significant safety concern, the patient's passes should be automatically revoked until after a documented consultation with either a resident or attending physician can take place.

THE PASS BOOK

Evidence

[32] The Court heard evidence about the procedures and practices surrounding the use of the pass book. Of note, despite ward policy, Ms Maciocha on the evening before her death, in the face of her sister's extreme concern, was allowed to leave the ward to walk her sister out to her car without signing out - even though she was already signed back in. On the morning of her death, Ms Maciocha signed herself out for a two-hour walk with no opposition from staff - despite the concerns

about her condition and the fact that Dr. Gill had intentions of seeing her sometime that day. Staff testified that they often are too busy to monitor patient comings and goings and sign-outs.

[33] By Ms Maciocha's own notation in the sign out book, she should have been back by 1:00 p.m. from her two-hour walk. She was not. No one seemed to notice that she did not return as promised at 1:00 p.m. until the Medical Examiner's Office phoned with news of her death some 45 minutes later. According to Mr. Les Cook, Manager of Patient Care, even an involuntary patient like Ms Maciocha would usually be given a one-hour leeway before the staff would take any action regarding her failure to return.

Issues

[34] The rules regarding the sign out book are loose. Although staff prefer that patients sign themselves in or out of the ward, noting both their destination and the length of time they intend to be gone, this preference is often ignored by patients. Medical staff who testified gave varying views on how stringently the sign out rules are to be enforced.

[35] In addition, at the time that the ward received notification of her death, Ms Maciocha should have already been noted by staff as AWOL, given that she had not returned by 1:00 p.m. from her walk. Not only had she not been declared AWOL by staff, the fact that Ms Maciocha had left the ward and the interaction with her primary nurse that morning had not even been documented in her chart. It is conceded that it may not always be significant for a patient to return 40 minutes late, but in the face of her sister's observations from the weekend, combined with the staff's own documentation of her deterioration, a patient as unstable as Ms Maciocha should have been declared AWOL immediately when she did not return on time. It is noted however that, tragically, compliance with the AWOL procedures in this case would not have resulted in a different outcome as it was already too late.

Recommendations

1. Before an off-unit privilege or pass is granted to a patient for the first time, a member of the treatment team will discuss with the patient his or her responsibility to sign out in the pass book before exercising off-unit privileges and to check in with a nurse before exercising a pass.

2. In addition to the current wording found with the Health Sciences Centre "Welcome to PY2, Adult In-Patient Unit" Brochure (Exhibit 2, C19),

additional information should be added to the brochure stating that it is the patient's responsibility to check in with a nurse prior to exercising passes.

3. Pass book sign out should be mandatory and the staff should enforce it.

4. The unit pass book should be standardized and in a typed format and include the following information:

   (a) the type of pass or off-unit privilege being exercised by the patient;

   (b) the date and time the patient leaves the unit;

   (c) the patient's destination; and

   (d) the date and time of the patient's return to the unit.

5. If the patient is exercising a pass, the patient should sign the pass book to confirm that he or she has checked in with a nurse prior to signing out.

6. There should be a mandatory assessment by a nurse that occurs before a patient leaves the hospital grounds on a pass and for patients returning to the hospital after an unescorted or overnight pass. Although a hospital policy currently exists on this issue, it appears to not be enforced (Exhibit 2, C13). Most significantly, the patient needs to be assessed to determine if there has been a change in their condition that would require a change in their observation level or passes. Whoever does this assessment should be required to document formally that the assessment has been done, and whether the passes or observation level of the patient require change as a result. In addition, the patient must be assessed not only to ensure that they took their medication but also checked for safety reasons to prevent them from bringing anything dangerous back onto the ward.

7. The policy regarding AWOL patients needs to be adhered to by staff (Exhibit 2, C14).

SUICIDE RISK ASSESSMENT PROCESS AND TRAINING

Evidence

[36] Ms Maciocha's sister brought Ms Maciocha back to the hospital early on the evening before her death, fearful that Ms Maciocha might harm herself. She relayed her fears to the staff at the desk, one of whom was Nurse Michelle Thorsteinson. It is not clear who else was at the desk. At that point, one of the nurses asked Ms Maciocha in her sister's presence "Do you feel like hurting

yourself?" Ms Wisniewski testified that Ms Maciocha answered "maybe" to this question. According to Ms Wisniewski, this response was particularly alarming as Ms Maciocha had never said that before. In response to this Ms Wisniewski indicated that the nurses said that they would get her primary nurse and talk to Ms Maciocha right away.

[37] Nurse Thorsteinson testified that Ms Maciocha's answer to that same question, to her at least, was that she wouldn't hurt herself, so she felt that Ms Maciocha would be safe until she could speak to her primary nurse. Significantly, she testified that she believes she asked Ms Maciocha not to leave the ward until after she had spoken to her primary nurse. However, Nurse Thorsteinson did not note her involvement or any of these conversations in Ms Maciocha's chart, nor did she indicate on the chart that the patient had been asked not to leave the ward for the time being.

[38] Nurse Thorsteinson testified that she reported the concerns to Nurse Latour, Ms Maciocha's primary nurse, who she believed would have confined Ms Maciocha to the ward for the evening. However, Nurse Latour did not revoke Ms Maciocha's passes or consult with the resident or attending psychiatrist to get advice on whether Ms Maciocha's passes should be revoked or her observation level changed. Nurse Latour testified that she took no protective action, in part because she relied on the fact that Ms Maciocha was Roman Catholic and had stated in the past that suicide was against her religion. She also indicated that she believed that Ms Maciocha was "contracting for safety". Nurse Latour's conclusion is somewhat perplexing given the chart notes that Ms Maciocha was also feeling "hopeless, suicidal and that it was better not to live". These notations from Ms Latour on the chart suggest that the messages Ms Maciocha was giving were mixed at best.

[39] In hindsight, the feedback from family and comments and feelings of hopelessness expressed by Ms Maciocha should have sounded sufficient alarm bells that evening to trigger a temporary revoking of Ms Maciocha's passes or, at minimum, a consultation by the nurse with a resident or attending psychiatrist. However, neither these comments nor the information from Ms Maciocha's sister appear to have been deemed sufficient by staff to revoke Ms Maciocha's passes, even temporarily, or to seek immediate advice from a physician that evening.

[40] By the next morning, Ms Maciocha's condition had deteriorated to the point that it was visible from brief contact. Nurse Marlene Combot, who was not even Ms Maciocha's nurse, attested to noting the deterioration and severe depressed affect that Ms Maciocha was exhibiting the morning of her death. She was

concerned enough that she went right away and told Nurse Debra Burda and Dr. Gill. Nurse Combot testified that she assumed Ms Maciocha would be reassessed regarding pass privileges.

[41] Nurse Debra Burda was Ms Maciocha's primary nurse that morning. She noted Ms Maciocha's depression and, according to the evidence she gave in Court, said she questioned Ms Maciocha about whether she was suicidal and that Ms Maciocha denied being suicidal. Although Nurse Burda testified that she spent 20 minutes with Ms Maciocha in a "one on one", she did not document this interaction on the chart. She, too, took no action to revoke Ms Maciocha's passes.

[42] The Inquest later heard through Dr. Yaren that the concept of "contracting to safety" is a concept that has come and gone in the mental health field. It turns out to not necessarily be a reliable indicator of suicidal behaviour. Although it remains a tool, it does not carry the weight previously thought. The Court also heard that the religious beliefs of a patient have also not proven to be a good prognostic tool in predicting the risk of suicide.

[43] The medical student who had been on the ward for approximately five days met with Ms Maciocha for about 15 minutes less than an hour before Ms Maciocha committed suicide. The student documents thoroughly and conscientiously the content of that meeting. At that meeting Ms Maciocha refused to say yes or no to questioning about whether she intended to hurt herself. This student took no action to change Ms Maciocha's status or revoke her passes. Dr. Gill pointed out that Ms Maciocha also indicated that she knows there is happiness in the world, she is just unable to feel it and that she has some hope for the future. At its most optimistic, the message from Ms Maciocha regarding her suicide ideation at this point could be described as mixed but concerning.

[44] There appears to have been differing reactions amongst the ward staff to Ms Maciocha's deterioration and the family concern in the hours before Ms Maciocha's death. Unfortunately the evidence is unclear in this area due both to insufficient charting and to unclear memories. One thing is clear. Despite the concerning information from Ms Maciocha's family and documented increase in Ms Maciocha's hopelessness, none of the medical team who were responsible for Ms Maciocha's care took any formal action to change her observation level or to revoke her passes.

Issues

[45] The Inquest heard that medical staff place great weight on the patient's own response to whether they intend to harm themselves. To a lay person, this seems somewhat counter-intuitive, given that an involuntary patient would be compelled to answer such questions falsely if they had a desire to carry out a successful suicide while in hospital against their will. The Court was assured, however, that patients routinely answer these inquiries honestly and that it can be a prognostic tool. Indeed, in Ms Maciocha's case, it appears that Ms Maciocha was honest about her intentions when she refused to admit to the medical student that she would not harm herself and then within the next hour did, in fact, commit suicide.

[46] According to the psychiatric testimony, it is clear that some of the diagnostic indicators relied on by some staff in assessing Ms Maciocha's risk were not considered reliable based on current psychiatric wisdom. There is no proven link between a person's religion and their suicide risk. Contracting for safety is often not a sound strategy.

[47] There were many alarming signals in Ms Maciocha's case in the 24 hours prior to her death that failed to generate any protective action by her medical team. Most notably, collateral information from the family that she had "never been this bad" and Ms Maciocha's visible deterioration resulted in no significant response by her team. Each member of her team testified that, based on their own particular suicide risk assessments, Ms Maciocha was not at risk. Yet, Nurse Combot, who was not in direct care of this patient, was concerned enough from a brief contact with Ms Maciocha to interrupt Dr. Gill during a meeting to tell her that Ms Maciocha needed to be seen.

[48] There is no mandatory specific suicide risk assessment training for the nursing staff. Many of the staff had received no specific training in this area at the time of Ms Maciocha's death. Since Ms Maciocha's death, some staff have taken the ASIST program (Applied Suicide Intervention Skills Training). This program, however, is geared mainly to professionals who work in the community (Exhibit 7, Tabs 4 and 5).

[49] The in-house orientation deals, in part, with suicide. It is mandatory for any new nurse who has not worked on a psychiatric ward in the past. The suicide risk component of this course is a half day. The main components of the course are found at Tab 2 and Tab 3 of Exhibit 7. There is no indication that the course deals with the controversy regarding contracting for safety or the reliance on religious beliefs as a protection against suicide.

Recommendations

1. The Winnipeg Regional Health Authority should immediately introduce mandatory training on suicide risk assessment. It should be a comprehensive standardized course or workshop for nurses working on in-patient psychiatric units (the "Main Course"). The content of the course should be reviewed by a psychiatrist. It should be mandatory for all nurses who accept employment on an in-patient psychiatric unit to take the Main Course. Further, all nurses who currently work on an in-patient psychiatric unit should be required to take the Main Course.

2. The Winnipeg Regional Health Authority should introduce a standardized refresher course on the issue of suicide risk assessment for nurses working on in-patient psychiatric units (the "Refresher Course") which will not be as lengthy or as detailed as the Main Course. The content of the course should be reviewed yearly and updated if necessary by a psychiatrist. It should be mandatory for all nurses who work on an in-patient psychiatric unit to take the Refresher Course every year.

3. When medical students commence a rotation on an in-patient psychiatric unit, they should participate in a mandatory orientation session that will include instructions by a psychiatrist or resident on the issue of suicide risk assessment.

4. Involuntary patients should be reassessed every day by either a medical student or psychiatric resident and reviewed with the patient's attending psychiatrist.

CHARTING

Evidence

[50] The procedures both for the recording of information on the chart and for reading the chart differ between staff members. Generally speaking, the staff on PY2 seem to employ the "charting by exception" style of charting. Although it was clear that a patient's chart should be read by each staff member when they started their shift, it was equally clear that this sometimes did not happen. In fact, the Manager of Patient Care, Mr. Cook, testified that if too much detail was put into a chart note, he feared that nurses would not bother reading the chart. For example, the medical student who met with Ms Maciocha an hour before her death was unsure if she had read the chart notes from the night before. A nurse who was very concerned about Ms Maciocha on the morning of her death went and told

Dr. Gill and the resident verbally that Ms Maciocha needed to be seen as she feared that if she only wrote it on the chart it might not get read.

[51] The Court was advised that critical incidents are to receive priority and require charting immediately as soon as the patient is safe. Timing of note-taking is, understandably, an issue of priorities. Every one-to-one therapeutic interaction should have a chart note.

[52] It was also clear from the evidence that charting notes are often not made contemporaneously with events and, in fact, the documentation sometimes is not done till the next day. A significant example in this case is the fact that the notation from Ms Maciocha's primary nurse that Ms Maciocha had left the ward at 11:00 a.m. on the morning of her death for a two-hour walk was not even documented until, coincidentally, five minutes before the Medical Examiner's Office called the ward looking for Ms Maciocha's file. By that time her absence should have resulted in considerable concern on the part of staff, but instead appears to have gone unnoticed.

[53] The chart itself was filed as an exhibit. It reveals many instances of illegible handwriting. This is unacceptable and dangerous given the import of the information recorded. Even the last entry on Ms Maciocha's file is almost illegible. It is trite to state that the minimum acceptable standard for charting should be legibility.

Issues

[54] The committee from the Health Sciences Centre and the witnesses have emphasized the competing priorities facing staff when it comes to finding time for charting, i.e., the balance between actual patient care versus charting and reviewing charts. In addition, not all communication is charted; much is oral. Lastly, there must be a necessary balance between recording all important information and excessive and redundant notes.

Recommendations

1. It must be made mandatory that all nurses read the chart and provide their updates as required on each of their patients at the start of their shift. To ensure that this happens, nurses should be required to sign the chart after reading the chart entries from the previous day.

2. Charting must be legible, whether that goal is achieved by the eventual introduction of electronic charting or not. Electronic charting would assist

in ensuring the legibility of patient charts. It could also allow for the networking of information to avoid having to record it in multiple places. If illegible entries continue, the supervisory staff needs to take appropriate action as an illegible chart is meaningless and potentially puts patient care at risk. The Winnipeg Regional Health Authority should continue its efforts to implement the Hospital Information System as set out in the overview at Exhibit 7, Tab 10.

3. Verbal notification of any safety issue involving a patient takes priority over the charting of the concern, but charting of any safety issue involving patient should be done contemporaneously with events or as soon thereafter as possible.

4. Medical students write a sign over note on the chart to summarize the patient's care and progress when another medical student is to assume conduct of the patient's care. Primary nurses should adopt the same practice.

5. The Health Sciences Centre Program should review its current charting practices and develop charting guidelines or a policy that will provide, among other things, that:

   (a) notes must be legible;

   (b) notes should be recorded as soon as reasonably practicable;

   (c) when it is reasonably practicable to do so, doctors and nurses should review the recent entries on a patient's chart prior to seeing the patient;

   (d) typically, notes should include clinically significant observations and facts; and

   (e) safety concerns should be emphasized and highlighted.

RESOURCES

Evidence

[55] Although it remains somewhat unclear from the evidence, it appears that in almost two months of involuntary admission, Ms Maciocha saw an attending psychiatrist, at most, eight times. Dr. Zimmer did not see Ms Maciocha at all although he was her attending psychiatrist for a week. Dr. Gill was the lone

psychiatrist on a very busy morning on the day Ms Maciocha died, so busy she had not yet had time to assess Ms Maciocha's deterioration before she left the ward.

[56] Ms Maciocha's death occurred on a Monday. Monday is the busiest day of the week on the ward, in part due to the fallout from the weekend in emergency and because there are numerous new admissions over the weekend. Dr. Gill was the lone attending physician on a ward of about 25 patients on that day. It was her first day back from holidays. Dr. Zimmer, the psychiatrist with whom she shared the ward and responsibilities, was not there, as he had just begun his holidays on the day of Dr. Gill's return. Dr. Gill, on the busiest day of the week, had a number of competing demands for her time. The entire medical staff is particularly busy on Mondays and it was clear that Dr. Gill was very busy.

[57] Mr. Cook, Manager of Patient Care, testified that there were no unaddressed resource issues and that resources were sufficient on the ward. Despite his evidence, the Court was left with the overall impression from most of the other witnesses that resources were limited. For example, nurses testified that they routinely assist with patients to whom they are not assigned. Nurses also indicated that they did not have time to read through files or to monitor patients leaving the ward or to chart contemporaneously. However, it must be noted that no nurse identified a lack of resources as contributing to any of the issues surrounding Ms Maciocha's death.

[58] It appears there is a disparity between the evidence of the Manager of Patient Care on the issue of resources and that of other members of the staff.

Issues

[59] How much of what happened with Ms Maciocha's case can be attributed to a lack of resources?

Recommendations

1. Consideration should be given to the provision of additional staff on Mondays to assist with the backlog of patient discharges, new admissions and other tasks.

2. For the continuity of patient care, attending psychiatrists should not, whenever possible, take back-to-back vacations.

3. The hospital should assess the feasibility of selecting a day other than Monday for the discharging of patients from this ward or consider spreading

discharges out over the course of several days to alleviate the pressure on the workload that arises on Mondays.

ACCESS TO PHYSICIANS AND PATIENT REQUESTS FOR TREATMENT

Evidence

[60] Ms Maciocha was in the hospital for 57 days from February 9 until the day of her death, April 5. Dr. Gill was Ms Maciocha's attending psychiatrist. Between February 9 and March 26, she met with Ms Maciocha eight times. Dr. Gill was on holidays from March 26 to April 5. During this time, Ms Maciocha was under Dr. Zimmer's care. Ms Maciocha never saw Dr. Zimmer throughout the period while he was responsible for her care, despite the fact that Ms Maciocha asked to see Dr. Zimmer and that the request was apparently brought to Dr. Zimmer's attention. From reading the chart, it is clear that Ms Maciocha was deteriorating during the time period when she requested to see Dr. Zimmer. It remains unclear to the Court why Dr. Zimmer did not evaluate Ms Maciocha even though she requested it, was decompensating and, further, had not been seen by an attending psychiatrist for days.

[61] In fairness, it should be noted that Ms Maciocha was seen frequently by a resident or medical student. In the last week of her life, the medical student was the only medical staff other than the nurses who was seeing Ms Maciocha regularly. This student had not even been on the ward a week and had received no specific suicide risk training. Ms Maciocha also requested that medical staff contact her former psychiatrist, who had some familiarity with her condition, to consult about her case. She advised that she had spoken to this psychiatrist and that he was expecting their call. No one ever called him.

[62] Lastly, Ms Maciocha was aware that Wellbutrin had helped her with her depressive episodes in the past and she made more than one request to be put back on this drug. Despite the fact that she was becoming more and more depressed as the days wore on, no one prescribed this antidepressant for her. Although the Court heard evidence that an antidepressant would have to be monitored carefully to ensure that the drug did not trigger a manic episode, given that Ms Maciocha was hospitalized, clearly she could have been monitored. This potential side effect should therefore not have been a bar to her receiving the drug. The resident at one point did suggest another drug to Ms Maciocha for her to consider. After this discussion, the resident still noted that Ms Maciocha was looking forward to starting the medication when Dr. Gill returned. It was clear from the evidence that Ms Maciocha wanted medication, needed medication, and knew that it had helped

her in the past. Yet still, all of the medical staff who heard Ms Maciocha's requests and knew that she wanted to start antidepressants simply deferred the medication decision until Dr. Gill's return. This delay was unfortunate, given Ms Maciocha's extreme depression and need for treatment.

Issues

[63] Ms Maciocha was becoming severely depressed during the last several days of her life. She was requesting medication that had helped her in the past. Her request for this medication met with a lengthy delay, awaiting the return of her original attending physician. She was requesting, and clearly needed, to be seen by an attending psychiatrist. No attending psychiatrist saw her from before Dr. Gill left on holidays on March 26 until her death on April 5.

[64] As the committee points out, resolution of this problem is complex. The issue is multi-faceted and involves resources, the importance of triaging patients, the importance of collaborative practice and the use of medical students and residents, in addition to an assessment of the patient's condition and level of acuity.

[65] Still, the problem must be addressed as the consequences arising from the problems in the case of Ms Maciocha were tragic. Ms Maciocha was an involuntary patient, detained against her will in a psychiatric ward, who was deteriorating and unable to access an attending psychiatrist during the ten days before her death.

Recommendations

1. The basic principle to be endorsed is that a patient should have access to his or her attending physician within a reasonable period of time. Patient requests for consultation with an attending physician should be documented and the response recorded as to how each request was addressed.

2. The patient should be advised of the reason for a refusal for a consultation with an attending physician.

3. The Health Sciences Centre Program should determine if there should be a standard for all in-patients on the issue of frequency of direct and personal assessment by an attending physician.

4. The Health Sciences Centre Program should review its process for responding to patient requests for consultation with attending physicians and endeavour to set guideline standards for patient care in this area.

5. The Health Sciences Centre Program should review its physician vacation coverage process to ensure that appropriate coverage is provided when colleagues take vacation/leave.

CRITICAL OCCURRENCE PROCEDURES

Evidence

[66] The policy in place at the Health Sciences Centre for when a critical occurrence review should be conducted is found at Exhibit 2, Tab 9 (3.5).

[67] The criteria for a review in accordance with this policy is as follows:

> Not all critical clinical occurrences will require this intensive review. Some factors to consider in determining which occurrences should be assigned to a team are:
>
> 1. The level of seriousness, and
>
> 2. The potential for learning for quality improvement initiatives.

[68] In this case there was no critical occurrence review team investigation ordered in accordance with 4.3.5 of the Winnipeg Regional Health Authority critical occurrence policy. Instead, the Manager of Patient Care for that ward, Mr. Les Cook, was asked to conduct an investigation into what occurred and complete a report.

[69] This decision to not conduct an investigation in accordance with the policy and bring in a review team appears to have ignored the existing criteria in the policy. Certainly it was a very serious incident and there was much to learn from the incident. An independent review would have been very helpful in this case.

[70] It was Mr. Cook's own unit that had been caring for the Deceased when she took her life. Mr. Cook's investigation entailed reading the patient's chart and speaking with staff. He did not take notes during this investigation. He also did not require those involved in the Deceased's care to make notes. He testified notes were not required during his investigation. He also felt there was no need for correcting or improving upon what occurred. Significantly, he did not speak to

Ms Wisniewski about what had happened the night before her sister's death or immediately after her sister's death.

[71] Mr. Cook did not collect, copy or preserve any of the materials or tools of communication associated with the Deceased's care in the days prior to her death. This includes things such as the audio tape from the evening and night nurses, the kardex noting her privileges, the quick reference recipe card listing patient passes, the pass book with her sign out information, the portion of the doctors' clipboard with advisory comments and the sheet listing the primary and secondary nurses who were assigned to her care.

[72] The impression that Mr. Cook conveyed to the Court was that from the outset of his investigation he was satisfied that everyone had acted in a satisfactory manner. Mr. Cook testified that he felt that everything was done well by the nurses, even going so far as to call their conduct "exemplary".

[73] Mr. Cook completed a fill in the blank form, the substantive review portion of which consisted of six handwritten lines, much of which was difficult to read. The report was forwarded to hospital management, who determined on the basis of this report that no further investigation was necessary. Management was aware that an inquest would be called.

[74] Mr. Cook also did the debriefing with the staff. This meeting was not intended as a learning exercise. Staff described the debriefing as a meeting to deal with the emotions and the grief they were feeling rather than a critical review.

[75] It appears from a review of the emails and documentation after the event that the response was focused on "positioning" for the Inquest (to use the phrase from the email) rather than on helping the family and learning from the tragedy.

[76] Many of the witnesses who testified had trouble remembering important details. No one asked these witnesses to make detailed and independent notes after Ms Maciocha's death. Several witnesses testified that it would have assisted them in testifying if they had made notes at the time of the Deceased's death.

Issues

[77] Some of the witness testimony at the Inquest was unclear and evasive. Some of the lack of clarity was a result of poor memory that could have been improved by proper note making.

[78] A better understanding of the facts by the Court could have been achieved through the tendering of the documentary evidence like the clipboard notes and the oral tape. Also, having the parties involved write notes immediately after the incident would have assisted their memories, thereby eliminating some of the disagreements amongst witnesses on important facts. More precise evidence from the witnesses would have assisted the Court in determining why certain failures happened and how best to prevent future occurrences.

[79] The investigation that was undertaken by the Manager of Patient Care was superficial, and inadequate.

[80] Apparently a staff debriefing was held a couple of days after Ms Maciocha's death to help staff deal with their emotional response to her death. However, it appears that the meeting did not review the events and decisions leading up to Ms Maciocha's death in an analytical way to try to improve processes. Such a meeting likely would have provided a valuable opportunity for teaching and improvement of ward issues.

Recommendations

1. All staff involved in the care of the patient should be required to make notes of all of their involvement in the time period leading up to the patient's death. These notes should be made as soon as possible after receiving notification of the patient's death. Each staff member should be required to make their notes independently without consultation with other staff members.

2. After any suicide, or any attempts at suicide, by a patient while admitted to a psychiatric unit, efforts should be made to preserve the scene, including all physical and documentary evidence.

3. All communication tools including the patient's chart and the tape pertaining to the patient should be seized immediately and kept in a secure place for the investigators and court review.

4. Managers should not investigate critical occurrences related to their own unit. A manager outside of the unit should assess the event to ensure an objective and critical assessment without preconceived conclusions or bias.

5. After any suicide of a patient while admitted to a psychiatric ward, there should be a detailed review and frank evaluation. The purpose of the review will be to learn, rather than blame. At the very least, the review will include:

(a) at least two interviewers;

(b) interviews of all individuals who were involved with the patient's case;

(c) preparation of notes with respect to the information gathered during the interviews;

(d) a review of the patient's medical records; and

(e) preparation of a chronology and report that will set out the possible causes of the suicide and, if appropriate, recommendations to prevent a similar occurrence in the future, and an action plan with timelines. The report should then be used as a learning tool.

6. The report should then result in a "psychological autopsy" where the staff meet and review what happened in a non-threatening or blaming environment. Consideration should be given to the utilization of an outside facilitator for the meeting.

CONCLUSION

[81] Ms Maciocha's family did indicate to the Inquest that it was their hope and desire that some positive change could arise out of this tragic event. It is my hope that the recommendations in this report will help prevent other deaths of a similar nature from occurring in the future.

I respectfully submit my recommendations and conclude this report this 1st day of March, 2006 at the City of Winnipeg, in Manitoba.

"A. Catherine Everett"

A. Catherine Everett, P.J.

LIST OF RECOMMENDATIONS

COMMUNICATION WITH THE FAMILY

1. Information flow to the families of patients must be improved and the ability of the family to voice their concerns to the caregivers must be improved. The family needs to be given more information about how they can participate in the care of their relative and how to communicate their concerns to the caregivers.

2. The Mental Health Program should emphasize the importance of involving the patient's family members in the treatment provided to the patient, recognizing that in some cases this may not be appropriate.

3. Early in the admission process, inquiries should be made by the appropriate health care provider to determine the patient's wishes respecting disclosure of personal health information to family members. Personal health information may be disclosed, if clinically appropriate, in accordance with the patient's consent and privacy legislation.

4. Upon admission, the patient's noted contact or next of kin should be provided with The Family Orientation Pamphlet. The current pamphlet (Exhibit 7) does not go far enough. The pamphlet should be revised to include a personalized page for each patient that identifies the patient's primary and secondary nurses, the medical student and the resident involved and the attending physician and patient advocate, along with information about the best way to contact these individuals. If the patient has instructed that their family is not to receive information, that information should be documented on this page. The provision of this material should be documented on the patient's chart.

5. If appropriate and if the patient consents in advance, within a short period of time from the patient's admission, the appropriate health care provider will schedule a family meeting.

6. During the family meeting or other interactions with the patient's family, family members should be encouraged to provide information about the patient to the treatment team on an ongoing basis and, in particular, to communicate any perceived changes in behavior or any other concerns.

7. If the patient has consented to the disclosure of personal health information prior to the family meeting, and if clinically appropriate, the treatment team may disclose personal health information and discuss the current treatment plan in accordance with the consent given by the patient.

8. Early in the admission process the treatment team should advise family members that passes may be granted to the patient and provide basic information to the family about passes.

9. The Family Orientation Pamphlet (Exhibit 7, Tab 6) should be revised to include a section dealing with passes which will set out basic information about the purpose of passes and encouraging family members to discuss any concerns respecting passes.

10. The patient's attending physician should inform the family of the patient's death as soon as it is practically possible to do so. At that time, the attending physician should offer to meet with the family within a reasonable period of time to discuss the circumstances leading up to the suicide.

11. The Bereavement Consultant at the Health Sciences Centre should follow up with the family of the patient within a reasonable period of time following the death to determine whether the family has any outstanding issues with respect to the suicide and, in particular, whether the family has met with the patient's attending physician to discuss the circumstances.

12. The legislative limitations that are placed on medical staff need to be better understood by the health care professionals. An educational workshop should be provided to the medical team and staff educating them about the privacy legislation and how it impacts on communication with families.

GRANTING OR REVOKING PASSES

1. When the attending physician has been asked to see a patient because of a deterioration in the patient's condition, the patient's passes should be temporarily revoked and the patient should not be allowed to leave the ward until after the examination by the attending physician.

2. After returning from a pass that involves a family member, the unit staff should attempt to obtain information from that family member regarding the pass and the patient's behaviour on the pass and, based on the clinical importance of the information conveyed by the family, such information

should be both charted appropriately and relayed to the appropriate physician.

3. If a family member or patient caregiver requests that an involuntary patient's passes be revoked because of a suicide risk or significant safety concern, the patient's passes should be automatically revoked until after a documented consultation with either a resident or attending physician can take place.

THE PASS BOOK

1. Before an off-unit privilege or pass is granted to a patient for the first time, a member of the treatment team will discuss with the patient his or her responsibility to sign out in the pass book before exercising off-unit privileges and to check in with a nurse before exercising a pass.

2. In addition to the current wording found with the Health Sciences Centre "Welcome to PY2, Adult In-Patient Unit" Brochure (Exhibit 2, C19), additional information should be added to the brochure stating that it is the patient's responsibility to check in with a nurse prior to exercising passes.

3. Pass book sign out should be mandatory and the staff should enforce it.

4. The unit pass book should be standardized and in a typed format and include the following information:

   (a) the type of pass or off-unit privilege being exercised by the patient;

   (b) the date and time the patient leaves the unit;

   (c) the patient's destination; and

   (d) the date and time of the patient's return to the unit.

5. If the patient is exercising a pass, the patient should sign the pass book to confirm that he or she has checked in with a nurse prior to signing out.

6. There should be a mandatory assessment by a nurse that occurs before a patient leaves the hospital grounds on a pass and for patients returning to the hospital after an unescorted or overnight pass. Although a hospital policy currently exists on this issue, it appears to not be enforced (Exhibit 2, C13). Most significantly, the patient needs to be assessed to determine if there has been a change in their condition that would require a change in their observation level or passes. Whoever does this assessment should be required to document formally that the assessment has been done, and

whether the passes or observation level of the patient require change as a result. In addition, the patient must be assessed not only to ensure that they took their medication but also checked for safety reasons to prevent them from bringing anything dangerous back onto the ward.

7. The policy regarding AWOL patients needs to be adhered to by staff (Exhibit 2, C14).

SUICIDE RISK ASSESSMENT PROCESS AND TRAINING

1. The Winnipeg Regional Health Authority should immediately introduce mandatory training on suicide risk assessment. It should be a comprehensive standardized course or workshop for nurses working on in-patient psychiatric units (the "Main Course"). The content of the course should be reviewed by a psychiatrist. It should be mandatory for all nurses who accept employment on an in-patient psychiatric unit to take the Main Course. Further, all nurses who currently work on an in-patient psychiatric unit should be required to take the Main Course.

2. The Winnipeg Regional Health Authority should introduce a standardized refresher course on the issue of suicide risk assessment for nurses working on in-patient psychiatric units (the "Refresher Course") which will not be as lengthy or as detailed as the Main Course. The content of the course should be reviewed yearly and updated if necessary by a psychiatrist. It should be mandatory for all nurses who work on an in-patient psychiatric unit to take the Refresher Course every year.

3. When medical students commence a rotation on an in-patient psychiatric unit, they should participate in a mandatory orientation session that will include instructions by a psychiatrist or resident on the issue of suicide risk assessment.

4. Involuntary patients should be reassessed every day by either a medical student or psychiatric resident and reviewed with the patient's attending psychiatrist.

CHARTING

1. It must be made mandatory that all nurses read the chart and provide their updates as required on each of their patients at the start of their shift. To ensure that this happens, nurses should be required to sign the chart after reading the chart entries from the previous day.

2. Charting must be legible, whether that goal is achieved by the eventual introduction of electronic charting or not. Electronic charting would assist in ensuring the legibility of patient charts. It could also allow for the networking of information to avoid having to record it in multiple places. If illegible entries continue, the supervisory staff needs to take appropriate action as an illegible chart is meaningless and potentially puts patient care at risk. The Winnipeg Regional Health Authority should continue its efforts to implement the Hospital Information System as set out in the overview at Exhibit 7, Tab 10.

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   (a) notes must be legible;

   (b) notes should be recorded as soon as reasonably practicable;

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RESOURCES

1. Consideration should be given to the provision of additional staff on Mondays to assist with the backlog of patient discharges, new admissions and other tasks.

2. For the continuity of patient care, attending psychiatrists should not, whenever possible, take back-to-back vacations.

3. The hospital should assess the feasibility of selecting a day other than Monday for the discharging of patients from this ward or consider spreading discharges out over the course of several days to alleviate the pressure on the workload that arises on Mondays.

ACCESS TO PHYSICIANS AND PATIENT REQUESTS FOR TREATMENT

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4. The Health Sciences Centre Program should review its process for responding to patient requests for consultation with attending physicians and endeavour to set guideline standards for patient care in this area.

5. The Health Sciences Centre Program should review its physician vacation coverage process to ensure that appropriate coverage is provided when colleagues take vacation/leave.

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1. All staff involved in the care of the patient should be required to make notes of all of their involvement in the time period leading up to the patient's death. These notes should be made as soon as possible after receiving notification of the patient's death. Each staff member should be required to make their notes independently without consultation with other staff members.

2. After any suicide, or any attempts at suicide, by a patient while admitted to a psychiatric unit, efforts should be made to preserve the scene, including all physical and documentary evidence.

3. All communication tools including the patient's chart and the tape pertaining to the patient should be seized immediately and kept in a secure place for the investigators and court review.

4. Managers should not investigate critical occurrences related to their own unit. A manager outside of the unit should assess the event to ensure an objective and critical assessment without preconceived conclusions or bias.

5. After any suicide of a patient while admitted to a psychiatric ward, there should be a detailed review and frank evaluation. The purpose of the review will be to learn, rather than blame. At the very least, the review will include:

   (a) at least two interviewers;

   (b) interviews of all individuals who were involved with the patient's case;

   (c) preparation of notes with respect to the information gathered during the interviews;

   (d) a review of the patient's medical records; and

   (e) preparation of a chronology and report that will set out the possible causes of the suicide and, if appropriate, recommendations to prevent a similar occurrence in the future, and an action plan with timelines. The report should then be used as a learning tool.

6. The report should then result in a "psychological autopsy" where the staff meet and review what happened in a non-threatening or blaming environment. Consideration should be given to the utilization of an outside facilitator for the meeting.

CHRONOLOGY OF KEY EVENTS

1. Ms Anna Maciocha was born in Poland on March 12, 1977 and immigrated to Canada in 1996.

2. While in Poland, Ms Maciocha was diagnosed as having Bipolar Mood Disorder (BMD), also known as Manic Depression.

3. On February 8, 2004, the Winnipeg Police Service, acting on an Order for Involuntary Medical Examination, apprehended Ms Maciocha at her apartment.

4. Her family had become alarmed by her recent erratic behaviour; they recognized it as mania and in need of medical intervention.

5. Ms Maciocha was taken to Emergency at the Health Sciences Centre at 1901 hours.

6. At 2200 hours Psychiatry was called and assessed Ms Maciocha as having BMD with hypomanic presentation: query psychosis and depression.

7. On February 9 at 0110 hours, she was admitted as an involuntary patient to PY2, a ward in the PsycHealth Unit.

8. Ms Maciocha was placed on Suicidal Observation; she changed into hospital garb and her own clothes were locked up.

9. The doctors, nurses and other professionals charted Ms Maciocha's progress on the Patient Progress Notes in her chart.

10. Her nurse for the day, Ms Karen Burgess, RPN (Registered Psychiatric Nurse), assessed Ms Maciocha as agitated and a risk for violence and elopement; hence she was sedated.

11. At 1230 hours, a third year Medical Student (Wawrykow) took Ms Maciocha's history.

12. Ms Maciocha denied wanting to hurt herself.

13. She also did not agree that she was manic.

14. Ms Maciocha relayed that she had not seen her psychiatrist, Dr. Roman Seifer, for two years nor was she on medication.

15. Ms Maciocha said that she was hospitalized in Poland and treated with Lithium (a mood stabilizer) and Clozapine (an antipsychotic).

16. The medical student found Ms Maciocha to be labile and inappropriate with many delusions and religious references but having no suicidal or homicidal ideation.

17. Ms Maciocha was admitted under Attending Psychiatrist Dr. Eunice Gill.

18. Dr. Gill ordered (by phone) Ms Maciocha to receive Olanzapine Zydis (antipsychotic) at Hs (bedtime).

19. On February 10, Nurse Burgess charted that Ms Maciocha was irritable and her mood labile; she was not accepting being on observation. Nurse Burgess assessed Ms Maciocha as agitated and manic with a risk for aggression towards others and property.

20. Nurse Burgess called security and other staff to assist in returning Ms Maciocha back to her room from the shower.

21. Ms Maciocha was informed of her right to apply to the Mental Health Review Board concerning her involuntary and incompetent status and given Form #18. Form #18 is an application for review of the patient's case by the Review Board.

22. At 1720 hours on February 11, Dr. Gill charted that she spoke with Ms Maciocha's father and sister, Ms Dorota Wisniewski, the evening of February 9; she discussed treatment issues with the sister. It was determined that Ms Wisniewski (whose grasp of English was better than the father's) would be the family contact.

23. Ms Wisniewski gave consent for her sister's treatment and oral and IM (intramuscular) medications.

24. Ms Wisniewski indicated that this is Ms Maciocha's fourth episode of mania; of those, two occurred in Canada.

25. Dr. Gill also spoke with Ms Maciocha who did not feel that she needed ongoing treatment with medication and was adamant about not taking LiCO3 (Lithium Carbonate).

26. On February 13 the chart indicated that Ms Maciocha completed Form #18 and it was forwarded on to the appropriate person.

27. At 1600 hours on February 13, the third year Medical Student charted that he/she spent about 45 minutes with Ms Maciocha.

28. Ms Maciocha spoke rationally about her religious beliefs.

29. Ms Maciocha wanted a weekend pass and threatened to sue Dr. Gill and the hospital when her request was denied.

30. The Medical Student assessed that Ms Maciocha was hypomanic but much better than on admission.

31. By evening, Ms Maciocha's mood was labile, her speech pressured and her movements restless; sedation was required.

32. At 1300 hours on February 15, the Medical Student, Wawrykow, charted Clerk Signover with a summary of the case and treatment plan.

33. At 1925 hours the nurse charted that Ms Maciocha was found in clothes from another patient. The clothes were confiscated.

34. Ms Maciocha's roommate alleged that she said "she will kill herself tonight or leave the unit"; Ms Maciocha denied this.

35. The assessment was that Ms Maciocha had manic presentation with very poor boundaries and insight.

36. During the late evening, the nurse charted that Dr. Gill met with the patient and her sister.

37. The night nurse charted on February 17 that Ms Maciocha was awake most of the night. She was argumentative and agitated, screaming thoughts about the devil.

38. The evening of February 17, Ms Maciocha was started on Epival (anticonvulsant). From her behaviour the nurse suspected that she was attempting to cheek her medications.

39. On February 18, Nurse Burgess charted that Ms Maciocha was very agitated. She stated she was going to go home or kill herself; she was pacing her room and threatening to die.

40. Ms Maciocha was taken to the seclusion room.

41. At 0915 hours, when Ms Maciocha began hitting the walls of the washroom, a Code White was called and security escorted her back to the seclusion room.

42. At 1630 hours, Dr. Gill charted that she met with Ms Maciocha's sister the evening of February 16. Ms Wisniewski gave her consent for Ms Maciocha to be started on Epival.

43. On February 19 at 1720 hours, A. Cassano Bailey, the new medical clerk, charted that Dr. Gill explained to Ms Maciocha why she required treatment and seclusion. She also told Ms Maciocha that the effects of the medication (Clopixol) Accuphase (antipsychotic) would continue to wear off.
Ms Maciocha was teary but settled after speaking with Dr. Gill.

44. On February 20, Medical Clerk A.C. Bailey spoke with Ms Maciocha about 20 minutes. She became increasingly agitated.

45. Ms Maciocha requested a pass to go home to her apartment on the weekend.

46. Ms Maciocha stated she wanted DNR (do not resuscitate) orders and did not want an autopsy if she died "in autopsy" but would allow the clerk to perform an autopsy if she could go home.

47. The clerk advised her that she was not well enough to go home. She could discuss her case before the Review Board on February 25.

48. Ms Maciocha denied any suicidal ideation.

49. The evening of February 22, Nurse Burgess noted that Ms Maciocha brought an Epival tablet to her claiming it was from several days ago. It appears she had "palmed" medications.

50. Nurse Burgess charted that Ms Maciocha had a manic episode but was beginning to express increased insight and better judgment to manage her symptoms.

51. On February 24 at 1500 hours Medical Clerk A.C. Bailey charted that she met for 30 minutes with Dr. Gill and Ravi Gupta.

52. She also had a long discussion with Ms Maciocha in the morning about her Review Board meeting the next day at 4:00 p.m.; she explained the purpose of the meeting as well as how it would be conducted.

53. Ms Maciocha was ambivalent about attending the meeting until she was denied her request for a pass.

54. Medical Clerk A.C. Bailey found Ms Maciocha to be manic but improving.

55. Ms Maciocha continued on close observation.

56. The afternoon of February 25, Ms Maciocha attended the Review Board meeting to discuss her status; she stated the meeting was satisfactory.

57. On February 26 at 1630 hours, Psychiatry Resident Dr. Jane Moody charted that she spoke with Ms Maciocha about 45 minutes.

58. She found her irritable and difficult to control but Ms Maciocha expressed no suicidal or homicidal ideation.

59. At 1700 hours Medical Clerk A.C. Bailey recorded that she received Ms Maciocha's permission for medical students to interview her, although the nurse charted that Ms Maciocha yelled at the student doctor and name-called.

60. On February 27 at 1015 hours Medical Clerk A.C. Bailey ordered on the Physician's Order Sheet, and Dr. Gill co-signed, that Ms Maciocha could go on 30-minute walks with staff or family only.

61. Ms Maciocha was also allowed to wear her own clothes.

62. Close observation was discontinued.

63. At 1700 hours, Medical Clerk A.C. Bailey charted that she met with Ms Maciocha in the morning, at which time Ms Maciocha expressed her fervent desire to return to her apartment.

64. Ms Maciocha heard that the Review Board maintained her status as an involuntary patient and the Certificate of Incompetence to Make Treatment Decisions was upheld. She was very upset with the decision at first, but came to accept it.

65. Since Ms Maciocha continued to exhibit symptoms of mania, the clerk assessed her as having manic episode.

66. The nurse charted that Ms Maciocha enjoyed a walk with a male friend.

67. Ms Maciocha had two walks on February 28 but seemed to respond to the stimulation poorly and required sedation.

68. On March 1 at 1305 hours, Medical Clerk A.C. Bailey charted that Ms Maciocha met with the Psych Team and was very happy when they granted her weekend privileges.

69. The medical clerk decided that Ms Maciocha had manic episode with decreased symptoms.

70. On March 3 at 1540 hours, Medical Clerk A.C. Bailey met one-on-one with Ms Maciocha for about 20 minutes in her room. She found Ms Maciocha to have manic episode with continued symptoms of mania but had improved somewhat since yesterday.

71. Her dose of Epival was increased and she was allowed a three-hour pass with her sister as per orders from Dr. Gill.

72. Again on March 5, Medical Clerk A.C. Bailey met with Ms Maciocha one-on-one for 40 minutes in her room.

73. A list of family and friends who were allowed to accompany Ms Maciocha on her 30-minute walks was written on the chart.

74. Ms Maciocha stated that she was depressed and denied that she was now manic.

75. Ms Maciocha demonstrated fleeting insight and judgment and was very labile.

76. She was still considered hypomanic and her weekend privileges remained the same.

77. On March 7 at 1530 hours the nurse charted that Ms Maciocha returned from a two-hour pass with her sister in the morning. The sisters disagreed on a matter and Ms Maciocha was close to tears but controlled herself with assistance.

78. The nurse felt that she was labile and hypomanic; passes were held for the rest of the day.

79. The nurse charted that Ms Maciocha was tearful during the evening on March 8 stating she wished she could just disappear; “I’m tired of my life, for my birthday I just want to disappear.”

80. Ms Maciocha also stated that she would never take her own life because of her religious views but finds her life difficult at times.

81. She visited with a Bipolar Mood Disorder advocate in the evening and found the talk helpful and hopeful.

82. At 1600 hours on March 9, Medical Clerk A.C. Bailey met with Ms Maciocha for about 45 minutes at the window area.

83. Ms Maciocha complained of feeling depressed, stating “I told you this happens.”

84. She was weeping a great deal, became very sad and appeared defeated. She kept repeating, “I give up, you guys just do whatever.”

85. She denied suicidal thoughts because she is Catholic and wants to go to heaven.

86. Ms Maciocha requested that staff call Dr. Seifer because she contacted him last week and he is waiting for a call from them.

87. Medical Clerk A.C. Bailey determined she was hypomanic and queried depression. She wondered if they should start Ms Maciocha on Wellbutrin (antidepressant).

88. On March 10 the nurse charted that Ms Maciocha stated she was depressed.

89. On March 11 at 1630 hours Medical Clerk A.C. Bailey charted a late entry from March 10. She met with Ms Maciocha for about 20 minutes.

90. Ms Maciocha complains of feeling “down”; she states she knows she will become depressed because it happened the last time she was manic.

91. She doesn’t care to celebrate her birthday on Friday; “I just want to disappear”.

92. She would like to be a voluntary patient.

93. Ms Maciocha became very emotional and cried for the latter half of the interview. Medical Clerk A.C. Bailey's assessment was that Ms Maciocha was hypomanic and did not endorse enough symptoms of depression.

94. The plan was to increase her privileges to one hour (passes) accompanied by a friend or family and to give her a four to six-hour pass for her birthday.

95. March 12 was Ms Maciocha's birthday.

96. At 1500 hours Medical Clerk A.C. Bailey charted that she met with Ms Maciocha in the window area.

97. Ms Maciocha was very emotional. She stated she is "fucking depressed and no one is listening"; wants to disappear. She doesn't want any visitors for her birthday and doesn't care about passes.

98. Ms Maciocha expressed delusional and paranoid thoughts about staff and friends. She became very agitated, striking her head and body with both hands.

99. Ms Maciocha asked to end the interview so she could go to bed.

100. Medical Clerk A.C. Bailey assessed Ms Maciocha's mood as rapid cycling versus mixed mood and planned to discuss the situation with the team.

101. On March 15 at 1445 hours, the nurse charted that Ms Maciocha stated "My mood is so depressed; I need to be on antidepressants." Her mood was very labile; one moment crying, the next smiling.

102. At 1520 hours Medical Clerk A.C. Bailey charted that she met with Ms Maciocha for half an hour, at which time Ms Maciocha described the flow of her moods: worse in the morning, lowest in the early afternoon then increased manic symptoms during the evening.

103. Ms Maciocha finally used her birthday pass (four to six hours) by going to her apartment on the weekend with a friend.

104. The medical clerk went on to chart that "although patient is low in the a.m., she experiences passive suicidal ideation. Patient states low period is difficult; (she) feels empty and hopeless."

105. Ms Maciocha expressed no current suicidal ideation and stated she "wants to get better".

106. Medical Clerk A.C. Bailey's assessment was that she was showing improved insight. Ms Maciocha was in agreement that she was experiencing mixed episode.

107. Medical Clerk A.C. Bailey again met with Ms Maciocha in her room on March 17 at 1500 hours.

108. At that time, Ms Maciocha complained of feeling very fatigued and numb; she wanted this to "end". She feels indifferent about attending groups even though she can now go unaccompanied. She has no appetite during the day.

109. Ms Maciocha denied cheeking her medications over the weekend or vomiting them up.

110. Her mood continues to fluctuate during the day when she feels depressed but improves in the evening. Although Ms Maciocha's affect displays a complete range, her mood is mostly depressed.

111. Medical Clerk A.C. Bailey described Ms Maciocha as exhibiting symptoms of mixed episode.

112. On March 18 at 1430 hours, the nurse charted that Ms Maciocha was secluded to her room most of the day, sleeping. She seemed to be "dipping into a depressed mood".

113. On March 19, Medical Clerk A.C. Bailey recorded that she met with Ms Maciocha and Dr. Gill in the conference room.

114. Ms Maciocha was doing very well compared with the previous day; she reported feeling a little depressed in the morning.

115. Ms Maciocha stated that she has never had thoughts about harming herself when she feels down.

116. The assessment was that Ms Maciocha was still experiencing mixed episode but she was doing much better. Therefore her privileges were increased to two passes, each one hour long and unaccompanied, and one two-hour pass accompanied.

117. On March 22 at 1600 hours, Medical Clerk A.C. Bailey noted in Ms Maciocha's chart that her weekend pass went really well; she was looking forward to a pass on the coming weekend.

118. Medical Clerk A.C. Bailey felt that Ms Maciocha was still experiencing symptoms of mixed episode but was improved from last week. The plan was to "continue present management; if predominant mood becomes depressed, when patient is more stable will consider adding an antidepressant at that time".

119. On March 23, Medical Clerk A.C. Bailey charted that she met with Ms Maciocha at the window area. Ms Maciocha complained of increased fatigue, decreased energy, difficulty concentrating and suffered from a three-day bitemporal headache.

120. Medical Clerk Bailey indicated that Ms Maciocha was still in mixed episode.

121. On March 24 at 1415 hours, Medical Clerk A.C. Bailey met with Ms Maciocha in her room. Ms Maciocha expressed her concern about her weight gain of 30 pounds.

122. Ms Maciocha noted that her depressed mood was lasting longer in the day; she doesn't perk up until 4:00 to 6:00 p.m.

123. Medical Clerk A.C. Bailey still assessed Ms Maciocha as mixed episode.

124. The Psych Team met with Ms Maciocha on March 26 for approximately 20 minutes. Ms Maciocha described feelings of depression in the morning that declined as the day went on.

125. Ms Maciocha denied suicidal ideation.

126. The team described her as suffering from mixed episode, where her mood continues to fluctuate with depressive symptoms in the morning and hypomanic symptoms in the evening.

127. Her privileges were increased to two unaccompanied walks twice a day and dinner in the cafeteria.

128. Ms Maciocha was also given an unaccompanied day pass for Saturday, March 28 and Sunday, March 29. She was to return by 10:00 p.m.

129. At 1810 hours on March 26, Dr. Gill wrote on the Physician's Order Sheet that Ms Maciocha was transferred to Dr. Zimmer's care until 8:00 a.m. on April 5.

130. On March 29 at 1420 hours, Medical Clerk A.C. Bailey wrote a Sign-over note in Ms Maciocha's chart.

131. She charted "Last week patient began demonstrating symptoms of mixed episode therefore decision to add antidepressant for depression was held until predominant mood is depressed otherwise plan was to continue with monotherapy Valproic Acid."

132. Medical Clerk A.C. Bailey also charted that Ms Maciocha had symptoms of major depressive episodes (MDE). She feels completely slowed with decreased ability to concentrate and devoid of motivation. She finds herself very tearful even at home; she feels hopeless.

133. Ms Maciocha denied suicidal ideation.

134. To Medical Clerk A.C. Bailey, Ms Maciocha appeared to be suffering (from) a major depressive episode, no longer mixed. She noted that Ms Maciocha had previously been on Wellbutrin for depressive episode. The plan was to hold off adding an antidepressant in order to avoid incurring manic episode. Ms Maciocha had been predominantly depressed for approximately the last five days. She queried adding Wellbutrin or Lamotrigine (Lamictal) later this week.

135. At 2100 hours Nurse Debra Burda, RPN, charted that Ms Maciocha was concerned that she felt so depressed.

136. Ms Maciocha asked to speak to Dr. Zimmerman.

137. On March 30 at 1615 hours, the second year resident, Dr. Nadia Tomy, noted that she met with Ms Maciocha for 25 minutes.

138. Dr. Tomy found Ms Maciocha to be in the depressive phase of BMD. She discussed the possibility of treating Ms Maciocha with Lamotrigine (mood stabilizer) with the possibility of starting the drug on Monday.

139. Psychiatry Resident Dr. N. Tomy saw Ms Maciocha the morning of March 31. She discussed an alternative antidepressant treatment to Wellbutrin with Ms Maciocha. Ms Maciocha wanted to think about it; she would discuss the matter with Dr. Gill on Monday.

140. In a choice between taking Lamictal or Wellbutrin, Ms Maciocha preferred the latter even though with Lamictal (a mood stabilizer) there is less risk of triggering mania.

141. The resident noted that Ms Maciocha was mixed depression, mania resolved.

142. At 1430 hours the nurse charted that Ms Maciocha stated, “I’m feeling much more hopeful.” Even though she was feeling low, she felt that she would get better. She was looking forward to seeing Dr. Gill on Monday and starting on an antidepressant.

143. Ms Maciocha said that speaking with the priest also gave her hope.

144. At 1505 hours the new Medical Clerk, Hayley Menzies, charted that she met with Ms Maciocha for approximately 30 minutes.

145. Medical Clerk H. Menzies found Ms Maciocha depressed with low mood and decreased energy. She was looking forward to Monday when Dr. Gill returned because of the possibility of starting on antidepressants; she preferred Wellbutrin.

146. Ms Maciocha denied any thoughts of harming herself; because of her spirituality it is not an option.

147. Medical Clerk H. Menzies concurred with the resident that Ms Maciocha was mixed depressed and they should consider starting her on antidepressants on Monday.

148. On Thursday, April 1, Medical Clerk H. Menzies saw Ms Maciocha and found her mood unchanged. She again denied having thoughts about hurting herself. On April 2, Medical Clerk H. Menzies noted Ms Maciocha left for a weekend pass at 1100 hours.

149. On Sunday, April 4, Nurse Panchi Latour, BN, charted at 2210 hours that Ms Maciocha returned with her sister from her pass at 1900 hours, feeling very depressed.

150. Ms Maciocha said the pass was no good. She feels hopeless, even suicidal at times. She stated she wouldn’t do anything to harm herself but remarked “It is better not to live.”

151. Her sister, Ms Wisniewski, said Ms Maciocha was sad and crying with complaints of chest pain and feeling shaky. She did not eat or leave her apartment. She complained of seeing ghosts.

152. Ms Maciocha "contracted to safety" according to Nurse Latour who did not revoke her passes.

153. Monday morning, April 5, Medical Clerk H. Menzies charted at 1035 hours that she had spoken with Ms Maciocha for approximately 15 minutes.

154. Ms Maciocha did not feel like talking. When asked how the weekend went she replied that nothing goes well.

155. When asked if she had suicidal ideation she replied that she couldn't think and wouldn't know what to do. She did not answer yes or no to the question but denies that she feels life is not worth living.

156. Ms Maciocha said the world was beautiful and although she has some hope for the future, each minute feels like an eternity.

157. Her facial expression was flat, she made minimal eye contact and covered her face with her hands at times.

158. Medical Clerk H. Menzies determined that her depression had worsened dramatically over the weekend. She planned to discuss adding antidepressants to Ms Maciocha's treatment with Dr. Gill and wrote "Dr. Gill to see."

159. The last note on the chart is by Nurse Debra Burda at 1:40 indicating that Ms Maciocha had left on a two-hour unaccompanied pass at 11:00 a.m.

Chronology of Key Events Prepared By:
Betty Owen, Inquest Coordinator

WITNESS LIST

October 6, 2005 – Day 1

1. Dorota Wisniewski (nee Maciocha), sister of Anna Maciocha
2. Pancharathnan (Panchi) Latour, Bachelor of Nursing (BN), PsycHealth Unit, Health Sciences Centre
3. Debra Burda, Registered Psychiatric Nurse (RPN), PsycHealth Unit, Health Sciences Centre
4. Marlene Combot, RPN, PsycHealth Unit, Health Sciences Centre

October 7, 2005 – Day 2

5. Dr. Hayley Menzies, at the time, was a third year Medical Student (MS3), PsycHealth Unit, Health Sciences Centre
6. Michelle Thorsteinson, BN, PsycHealth Unit, Health Sciences Centre

October 11, 2005 – Day 3

7. Dr. Stanley Yaren, Psychiatrist and Deputy Head of the Mental Health Program, Health Sciences Centre

October 12, 2005 – Day 4

8. Dr. Eunice Charlene Gill, Attending Psychiatrist, PsycHealth Unit, Health Sciences Centre

October 14, 2005 – Day 5

9. Karen Dawn Burgess, RPN, PsycHealth Unit, Health Sciences Centre
10. Bruce Stevenson, Registered Nurse (RN), PsycHealth Unit, Health Sciences Centre
11. Luba Olesky, RN, PsycHealth Unit, Health Sciences Centre

October 19, 2005 – Day 6

12. Dr. Kenneth Wayne Zimmer, Attending Psychiatrist, PsycHealth Unit, Health Sciences Centre

October 20, 2005 – Day 7

No Witnesses

November 21, 2005 – Day 8

13. Leslie Louis Cook, RPN, Manager of Patient Care, PY2, Health Sciences Centre

14. Dr. Stanley Yaren (continuation)

November 22, 2005 – Day 9

15. Dr. Nadia Tomy, at the time, was a second year Psychiatric Resident (R2), Psych Health Unit, Health Sciences Centre

November 23, 2005 – Day 10

No witnesses

December 15, 2005 – Day 11

No witnesses

Submissions by counsel

EXHIBIT LIST

Exhibit No.	Description
1	Letter from the Chief Medical Examiner calling the Inquest
2	Binder labeled “Documents”
3	Winnipeg Police Service Narratives
4	Curriculum Vitae of Dr. Stanley Yaren
5	Mneumonic Notes
6	Restrictions on Use and Disclosure of Information from *The Personal Health Information Act*
7	Binder of Documents from the PsycHealth Unit, Health Sciences Centre