BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2008:0369:0149

An Inquest was held at the Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates June 1st-10th, 2009

before Liana Wright, Presiding Coroner,

into the death of ALLAN (Last Name) Ross Alexander (First Name) 22 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: April 15, 2008. early afternoon

Place of Death: MSA Hospital (Location) Abbotsford, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Anoxia

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Hanging

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural ☒ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 10th day of June AD, 2009.

LIANA WRIGHT

Presiding Coroner's Printed Name

Presiding Coroner's Signature

POSTED

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO.: 2008:0369:0149

SURNAME	GIVEN NAMES
ALLAN	Ross Alexander

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Liana Wright

Coroner's Counsel: Steven Boorne

Court Reporting/Recording Agency: Verbatim Words

Participants/Counsel:
Mr. and Mrs. Kim Allan, parents of decedent
Mr. Adam Howden-Duke (Fraser Health Authority)
Mr. David Pilley (Drs. Seimens and Strauss)
Ms. Helen Roberts (RCMP)
Mr. Grant Murray (Abbotsford Police)
Mr. David Martin (Intercon Security)

The Sheriff took charge of the jury and recorded 19 exhibits. Twenty two witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

Ross Alexander ALLAN was a 22 year old man who resided with his family in Mission, BC. Ross was hospitalized at MSA (Matsqui-Sumas-Abbotsford) Hospital in September 2007. He had been experiencing hallucinations and had a history of using illicit drugs. He was diagnosed with schizophrenia and he was followed by psychiatrist Dr. Strauss and the Mission Mental Health Team post discharge from hospital.

On April 11th, 2008, Ross did not show up for a scheduled appointment with his parents, psychiatrist and mental health worker. Based on the family's description of his recent behaviour, Dr. Strauss wanted to commit Ross as an involuntary patient under s. 22 of the Mental Health Act (MHA); however, he needed to see and assess Ross in order to do so. He instructed Mr. and Mrs. Allan to bring Ross to MSA Hospital on April 15th, 2008, when he would be on-duty so that he could certify him. He told the parents that if in the meantime matters were to worsen or they had any concerns, they could take Ross to their local hospital emergency room (ER).

On April 12th, Mission RCMP were contacted by Ross' parents regarding his increasing paranoid behaviour. He was arrested under the MHA and taken to Mission Memorial Hospital (MMH) ER at approximately 2000h. The ER was particularly busy that night. He was seen at triage and assessed as a CTAS Level 3 (Canadian Triage Acuity Scale), which indicates the patient should be seen by a doctor within 30 minutes. Ross, his parents and the police officer waited approximately 5 hours until the ER physician (ERP) was able to attend to him. The ERP certified Ross under s. 22 of the MHA, and documented his history of schizophrenia, illicit drug use, hallucinations and threats of self harm. There was no psychiatric unit at MMH, therefore Ross would need to be transferred to another facility. The ERP made an attempt to have Ross moved and contacted BCBedline for assistance. A psychiatric bed appeared to be available at Peace Arch Hospital (PAH). The ERP spoke with the psychiatrist on-call at PAH who refused to take Ross as a transfer during the night. His evidence was that although it appeared that a bed was available, he could not be certain. He further indicated that without the Bed Manager, Patient Care Coordinator (PCC) or Psychiatric Liaison Nurse (PLN) available for consultation, he could not be certain if the bed was empty or pending an admission of another patient from one of the

neighbouring hospitals they normally deal with. Ross remained in the MMH ER and his parents were assured that he would be watched by a second security guard that would be called in. The site leader, an RN responsible for overall operations after hours, gave evidence that because the ER was so busy that night, she worked in ER providing nursing care to patients and did not have the time to call in an extra security guard to sit with Ross. She reported that she checked on Ross every 15 minutes and that he slept. Shortly after 0600 hours on April 13th, the nurse reported seeing Ross running out of the ER wearing his hospital gown.

Ross eventually made his way back to his home. His mother informed Mission RCMP that he had arrived home and they attended and apprehended Ross. He was taken back to MMH ER but upon arrival, the police were instructed to take Ross directly to MSA ER under the 'No Refusal' policy. The 'No Refusal Policy' sets out clear criteria that must be met in order for a patient to be transferred to a hospital that offers a more specialized or higher level of care. The receiving hospital cannot refuse a patient if the criteria has been met. Ross was escorted to MSA ER where following a second assessment by an ERP, he was certified under the MHA. A second certification was made by the on-call psychiatrist on the morning of April 14th. The psychiatrist assessed Ross and found him to be not suicidal and not floridly psychotic. He diagnosed Ross with a drug-induced psychosis and placed him on a Level 2 of Nursing Observation. Evidence heard from physicians and nurses revealed that there was some confusion as to the interpretation of these levels. It appeared that the psychiatrists believed that when an admitted psychiatric patient remained in the ER awaiting a bed on the psychiatric unit, the Level of Observation that had been ordered would automatically be increased to a higher level of observation. There was some conflicting evidence from the nurses who appeared at inquest as to whether this unwritten rule was being consistently followed. We heard in evidence that when a psychiatric patient required watching, a nurse's aide would be called in to perform this task.

The jury heard in evidence that Mr. and Mrs. Allan contacted Ross' primary nurses on each shift and gave them some background information including their concerns that he was desperate to get out of hospital to obtain drugs and that he had told them he would commit suicide if he was ever hospitalized again. These conversations were not documented in any of the nurses' notes on the chart.

On the morning of April 15th, Ross was seen by his psychiatrist Dr. Strauss. Ross was stationed on a stretcher in a hallway, where he would have been exposed to the usual 'hustle and bustle' and noise of the ER. The jury heard that this would not be an ideal setting for a schizophrenic patient who would best be served by a quiet, less stressful environment. Dr. Strauss assessed Ross in a quiet room. He diagnosed him as not acutely psychotic. When he asked Ross about his suicide threat, Ross told him that he had only said that because he did not want to return to the psychiatric unit. At that time, Dr. Strauss did not believe Ross was suicidal. He increased Ross' observation level to Level 3, which he believed would be constant observation. The written policy in effect at that time indicates that Level 3 warranted checks conducted every 15 minutes.

Ross had been seen that morning by the Psychiatric Liaison Nurse (PLN) and was assigned to a primary nurse. The primary nurse was an experienced ER nurse, however, she was a new hire at MSA and although she had worked six orientation shifts this was her third shift on her own. She had not yet undergone the three day hospital orientation session due to scheduling conflicts. The primary nurse was assigned a workload of eight patients that morning, which soon increased to nine. She was made aware that Ross had been in the ER for three days and was brought to MSA following an elopement from MMH. She testified that she understood Ross to be diagnosed with drug-induced psychosis. After Ross was seen by Dr. Strauss, she learned that his level of observation had been increased to Level 3. She did not know exactly what this meant so she sought clarification from the ER PCC. Her evidence was that the PCC told her it meant the patient must remain on the unit, valuables were to be locked, dressed in hospital clothing and checks conducted every 15 minutes. She further testified that the PCC told her Level 4 observation had the same restrictions with the exception that constant observation was required. The PCC indicated that Ross was wait-listed for a bed on the psychiatric unit and would be moved as soon as one was available. The jury heard in evidence that three other psychiatric patients had been moved to the psychiatric unit between the hours of approximately 1945 hours on April 14th

to 1100 hours on April 15th. There were no documents available to determine who these patients were or the circumstances of their admissions.

Ross' primary nurse, that is the nurse assigned to his care, had a conversation with Mr. Allan on the morning of April 15th after he visited Ross. Mr. Allan told the nurse about his concern of Ross' drug-seeking behaviour. Later that morning after arriving home, Mr. Allan received a telephone call from Ross who was using the cellular phone of a taxi cab driver outside the hospital entrance. Ross requested his father's credit card number, which his father refused. Mr. Allan spoke to the cab driver and told him he would not pay for a taxi and immediately called Ross' primary nurse to tell her what had happened. The security guard was notified and a search of the common areas was conducted. The PCC was notified. She testified that because she believed Ross had left the hospital, she did not enact the Code Yellow missing patient search. This would have notified all hospital staff of a missing patient and would prompt them to search their respective areas. Abbotsford police were contacted and informed. The call was given a lower priority than it should have been which resulted in the call not being dispatched in a timely manner.

The body of Ross Alexander Allan was found at approximately 1600 hours in a locked staff bathroom. A subsequent review of the CCTV security camera footage revealed Ross wandering about the hospital. He was last known to be alive on camera footage at approximately 1154 hours, carrying an electrical cord which he had cut off from a bed stationed in a hallway. The investigation was not able to determine where he had obtained the knife. Despite resuscitative efforts by medical staff, Ross could not be revived.

ALLAN	Ross Alexander
SURNAME	GIVEN NAMES

Pursuant to Section 38 of the Coroner's Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: The College of Physicians & Surgeons of BC

1. That specific training and/or refresher courses be provided to physicians with respect to the legal test for committal under section 22 of the Mental Health Act.

2. That physicians are reminded of the importance of obtaining collateral information from family and caregivers in the assessment process of patients being certified under Section 22 of the MHA.

To: The College of Registered Nurses of BC and
The College of Registered Psychiatric Nurses of BC
The Minister of Health
Fraser Health Authority

3. That nurses are reminded of the importance of medical-legal charting including making complete and timely entries, as well as documenting late entries in accordance with best nursing practice.

4. That all nurses, physicians and other staff be properly trained on Code Yellow policy, and the implementation of a Code Yellow.

5. All health care workers are trained and have a clear understanding that when the police deliver a patient under the MHA it is their responsibility to ensure that these patients are unable to elope or wander freely about the hospital.

6. That all members of the health care team are trained that all MHA patients are for the most part, unable to provide true and accurate information on themselves. Therefore, the team must obtain and chart relevant collateral information from the family and/or other sources.

7. That Psych patients be discussed at all ICare meetings and Shift Change meetings so that the entire medical team is made aware of these patients.

   Coroner's Comments: The ICare meetings occurred daily each morning at MSA Hospital. This was a discharge planning meeting involving a multidisciplinary team approach during which patients' requirements for preparation for discharge were discussed. Psychiatric patients were not discussed at these meetings.

8. That collateral information regarding MHA patients be discussed and recorded in a patient's chart.

To: Minister of Health & Fraser Health Authority

9. That the Mental Health Act be revised to allow at the Psychiatrist's discretion, family members access to information, diagnosis, and inclusion in the treatment plan.

10. That the MSA recommendations arising from the death of Ross Alexander Allen be shared with all medical facilities.

    Coroner's Comments: The MSA recommendations refers to the s. 51 (Evidence Act) review that occurred following this incident. The jury heard evidence from a hospital administrator of the action items stemming from this review.

11. That Observation Levels should be standardized throughout all medical institutions and departments. These should be posted at all nursing stations especially in the Emergency Room.

12. That training with respect to the Levels of Nursing Observation be included in all orientation sessions for newly hired and existing Physicians, Nurses, Social Workers, LPN's and Care Aides.

13. That Code Yellow be activated whenever a patient detained under the Mental Health Act goes missing.

14. That Code Yellow Policy training be included in all orientation sessions for newly hired staff and inter-facility float staff (nurses, care aides, etc.).

15. That patients admitted under the Mental Health Act wear electronic monitoring bracelets restricting them to the Emergency Department. Or as an alternative in order to easily distinguish MHA patients, they be issued a brightly coloured (blue?) hospital wrist band. in addition to the regular hospital wristband.

16. That medical and nursing staff are reminded of the CTAS (Canadian Triage Assessment Scale) scoring levels and recommended wait times for triaged patients and that lengthy delays in assessment are subjected to a follow up review from a Quality Improvement perspective.

17. That site leaders at all hospitals are not routinely required to provide nursing care to patients in the ER unless all other means to call in extra nursing staff have been exhausted.

18. That an on-call nurse/bed manager be available for after hours consultation at PAH and any other hospital for BCBedline contacts that fall outside of the 'No Refusal Policy'. This will assist in ensuring that physicians contacted via BCBedline have current bed availability information to base their decisions on whether to accept or decline a patient transfer regardless of the time of day.

19. To provide at minimum one locking quiet room at all hospital emergency departments for patients certified and requiring observation while awaiting transfer to a psychiatric unit.

20. That at all hospitals one on one constant observation be required in the Emergency Department for any patient admitted involuntarily under s. 22 of the MHA until transferred to an appropriate department or facility.

21. To ensure that there are a minimum of 2 security guards on duty on a 24 hour basis at all hospitals.

22. That copies of the hospital chart accompany all patients transferred from one hospital to another, that the charts be accessible electronically and/or faxed within twelve hours of the patient's arrival.

23. That the ER staff routinely request or obtain any old charts from medical records upon a psychiatrist patient's presentation to the ER.

24. That cutting tools such as BCAS 'super scissors' are provided for security personnel.

    Coroner's Comments: The jury heard evidence that when security personnel discovered Ross' body hanging in the staff washroom, they did not possess any cutting tools to cut the body down. A paramedic, who was in the ER at the time, attended and used his 'super scissors' to cut the body down.

25. That when a patient with schizophrenia or other mental illness is admitted to the Emergency Room, every effort should be made to keep the patient in a calm, quiet environment with softer lighting.

26. That Bed census sheets and notes made by the PCC's on these sheets are kept on file so that patient transfers and the timeliness of these transfers can be tracked.

27. That a patient's family or contact person is notified as soon as possible when a patient is determined to be missing as per Code Yellow Stage One procedure.

28. That the patient's Most Responsible Physician or Psychiatrist is contacted as soon as possible when their patient is determined to be missing.

29. That documentation is maintained with respect to transfer of admitted patients from the ER to other wards, which includes patient name and time of transfer.

30. That upon admission all certified psychiatric patients be photographed and that the photograph be available for immediate distribution in the event of a Code Yellow search.

31. That in the event of a death such as this one that hospital administration ensures appropriate follow up is undertaken with the family.

    Coroner's Comments: The jury heard in evidence that Mr. and Mrs. Allan met with a social worker and hospital administrators on the day of Ross' death; however, there was a lack of follow up and emotional support for their family and the s. 51 review findings were not shared with them by hospital administration.

32. That a copy of the British Columbia Mental Health Act be made available and kept at all Nurse's Stations with periodic reviews in staff meetings.

33. That all staff areas be restricted by swipe card access, including staff washrooms, storage rooms and kitchen preparation areas, etc.

34. That when hospital staff is calling the police department they must maintain a courteous and professional demeanour.

    Coroner's Comments: The jury heard the audio recording of the call made by a staff member of the MSA ER to the Abbotsford Police Department following Ross' disappearance from the emergency room.

35. That in the event of a MHA patient eloping, the call should be a 911 call and not a non-emergency call.

36. That due to overwhelming substance-abuse issues throughout the province and the resulting increase in substance-induced psychosis, all hospitals provide mental health facilities sufficient to support their catchment area.

In addition, due to the statistic heard in evidence that one in every ten young adolescent men are at risk for developing schizophrenia, we make the following general recommendations:

37. That every effort be made to reduce the stigma of mental illness among young adults.

38. That a process be developed for early detection of young people at risk of developing mental health issues.

39. That in the case of a missing MHA patient, the security guard obtains a photo and physical description from the ward, and where possible quickly reviews the security tapes, prior to searching for the patient.

To: RCMP 'E' Division/All Municipal Police Services:

40. That transfers between hospitals and facilities with Psychiatric Units which involve separate police agencies be predetermined to facilitate the timely transfer of the patient.

41. That persons detained under the MHA by Police Agencies be taken to facilities with appropriate psychiatric care available.

42. That when call centre staff/complaint takers receive a call regarding missing patients, they maintain a professional and courteous demeanour.

To: Abbotsford Police

43. That lessons learned following the Ross Alexander Allen incident be shared with all police departments, particularly the priority levels assigned by communications to missing psychiatric patients.