BRITISH COLUMBIA

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OCT 28 2014

Ms. Lisa Lapointe
Chief Coroner
Ministry of Justice
BC Coroners Services
800 - 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Thank you for your letter of September 24, 2014, regarding recommendations from the Coroner's Inquest into the death of Mr. David Edwin Fast, BCCS Case File #2013-0376-0134.

Please be assured that your letter is receiving attention and that a more detailed response will be sent to you at the earliest opportunity.

Thank you,

Correspondence Coordinator
Health Services Policy and Quality Assurance Division

Ministry of Health
Health Services Policy and Quality Assurance Division
PO Box 9638 STN PROV GOVT
Victoria BC V8W 9P1

BRITISH COLUMBIA

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APR 2 3 2015

Ms. Lisa Lapointe
Chief Coroner
Office of the Chief Coroner
Ministry of Justice
Metrotower II
800 - 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

**Re: Coroner's Report into the death of Fast, David Edwin,
BCCS Case File #2013-0376-0134**

Thank you for your letter of September 24, 2014, regarding Recommendation numbers 9 - 16 made in the Coroner's Judgment of Inquiry into the death of Mr. David Edwin Fast. Please accept my apologies for the delayed response, as well as my assurance that work has moved forward since you released your report.

The Ministry of Health (the Ministry) has reviewed the recommendations and has the following response to each:

Recommendation #9: Explore providing health services in British Columbia Corrections facilities through a health authority.

The recommendation is under consideration. Since the outcome of the inquest, the Ministry of Health (the Ministry) and the Ministry of Justice have been in on-going discussions to understand the current service delivery model, identify gaps and look at options for a future service delivery model and governance structure. The findings and recommendations as a result of the inquest into Mr. Fast's death have been taken into consideration of this work.

Recommendation #10: Review the practice of involving police in the ongoing care plans of hospital inpatients.

The recommendation is accepted. Police are important partners in serving and protecting all British Columbians, including people with complex chronic conditions and mental health needs, as well as the people that care for them. Although not specific to the *Mental Health Act*, the police have the authority under both the Criminal Code and common law to protect life and property, preserve the peace and enforce the law. Therefore if a patient is causing a disturbance or is becoming violent, the police may intervene to help hospital staff.

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Ministry of Health | Office of the Minister | Mailing Address: PO Box 9050 Stn Prov Govt Victoria BC V8W 9E2 | Location: Parliament Buildings Victoria

To support this role, all police are now required to take Crisis Intervention and De-escalation Training, which includes training related to identifying and intervening in a mental health crisis. This training focuses on recognizing the signs and symptoms of mental health problems; how to provide initial help; and finally how to guide a person towards appropriate professional help.

Additionally, the Ministry and health authorities work together with police throughout BC on programs to provide the best possible care for vulnerable individuals. We have provided strong support for police integration and provided police with innovative tools, such as using improved record systems to better track contact and incidents where mental illness is involved.

Recommendation # 11: That guidelines and education on the application of the Adult Guardianship Act and the Mental Health Act be provided to all health practitioners whose responsibilities involve the care of vulnerable adults. This must include clear processes, including documentation for the initiation, continuation and discontinuation of the application of the provisions under these statutes. In particular, any person signing a certificate under these statutes must have directly assessed the patient, communicated the plans and, whenever possible, involved the family.

The recommendation is partially accepted as the recommendation is too broad - not all health practitioners involved in the provision of care for vulnerable adults need to be educated on the specific application of the *Adult Guardianship Act* and *Mental Health Act*. It is agreed that all health care providers responsible for administering and/or making decision under these Acts must be educated.

The *Mental Health Act* provides clear requirements for initiation, continuation and discontinuation of certificates. To make the *Mental Health Act* more understandable and to promote consistency in interpretation of the *Mental Health Act*, the province released the Guide to the Mental Health Act in 2005. All health authorities use the Guide to support their staff training and local protocols.

It is important to note that while the *Mental Health Act* does provide authority, criteria and procedures for involuntary admission and treatment, the *Mental Health Act* also contains protections to ensure these provisions are applied in an appropriate and lawful manner. Safeguards for the rights of people involuntarily admitted to a psychiatric facility include rights notification, medical examination at specified time periods, second medical opinions on proposed treatment and access to review panels and the court.

In order for a physician to fill out a medical certificate, the physician must have examined the patient and be of the opinion that the patient meets all four of the criteria for involuntary admission. The opinion must be based upon information from the examination and preferably include information received from family members, health care providers, or others involved with the person.

In regards to the *Adult Guardianship Act*, in addition to the Guide to the Certificate of Incapability Process developed by the Ministry of Justice and the Public Guardian and Trustee of BC and that came into effect December 1, 2014, the Ministry has committed to updating existing training on issuing Certificates of Capability to meet legislative changes.

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Recommendation #12: Consider the implementation of a process to assign a continuing case manager for patients with complex medical and or psychiatric conditions whose care involves multiple services and providers and sites of care including the community.

The recommendation is under consideration. The Ministry recognizes the importance for transition planning, which includes supporting required integration and continuity of care. Given the relatively short time that individuals may be incarcerated in the BC Correctional system(i.e. two years less a day and often significantly shorter lengths of time) connecting inmates to community based health services prior to release is critical to ensure continuity of care and reduction of repeat exacerbations and reoffending.

The Ministry, working with the Ministry of Justice, is reviewing an Implement APIC (Assess, Plan, Identify, Coordinate) Model to ensure coordination and continuity of care upon release from custody. Additionally, discussions are also on-going regarding implementing Community Transitions Teams that would be responsible for planning an inmate's release to community, including access to required medications and community health resources. This enhancement to transition planning aligns with the "Partners in Change: Enhancing Continuity of Care" initiative which aims to improve continuity of care for adult corrections clients experiencing mental health and/or substance use problems at key transition points between the correctional and health care systems where individual vulnerability for relapse of gap in treatment is high.

Recommendation #13: Develop guidelines to ensure that whenever possible patients and families are directly involved in meetings regarding the planning of their care.

The recommendation is under consideration. Patient centred care is fundamental to how we deliver health care services. As part of the current review work, it is recognized that there is a need to strengthen the relationships between patients and health professionals, correctional security staff, the inmate and others when delivering health care services in correctional facilities. This recognition includes strengthening communications between all parties and ensuring that correctional staff responsible for the day-to-day care of inmates are using a health care focus.

Recommendation #14: Required the completion, at monthly intervals and at discharge, of comprehensive accurate summaries covering the medical, social and psychiatric needs of patients in hospital and the required plans for treatment and care. These documents must have sufficient information to safely manage ongoing care by any provider and should be available electronically in a timely fashion. In addition, these should be shared with the patient or their substitute decision maker. In cases where a patient has been identified as vulnerable or medically fragile these summaries must be available immediately for access when the patient leaves the institution.

The recommendation for monthly summaries is rejected. All health authorities have, and are expected to adhere, to professional documentation standards. Additionally, discharge summaries are required to be produced by the most responsible professional for all patients. Health Records would be shared with patients/their families within the provision of the *Freedom of Information and Protection of Privacy Act of British Columbia* and the appropriate health authority policy. The Ministry does agree that the system should be striving towards the sharing of electronic medical records with appropriate parties once the appropriate infrastructure is in place.

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Recommendation #15: In Cases where a patient has been identified as having an unstable life threatening medical condition and they have discharged themselves against medical advice, every effort should be made by care staff to contact the patient, family and other care providers and to follow up to ensure that care is available.

This recommendation is not accepted. The health care system must comply with provincial legislation, including: the *Health Care (Consent) and Care Facility (Admission) Act* and Regulations; the *Adult Guardianship Act* and the *Freedom on Information and Protection of Privacy Act*.

Persons that are deemed capable of making decisions about their health care have the right to refuse or withdraw consent for treatment, even if the refusal will result in death. For persons deemed to be non-capable of making decisions, there are tools/processes in place (e.g. involuntary admissions under the *Mental Health Act*; appointing a guardian under the *Adult Guardianship Act*) to protect these individuals, including determining when it would be appropriate to inform next of kin or a substitute decision maker.

Recommendation #16: Explore the development of low-barrier long-term care facilities for patients with complex medical and or psychiatric conditions whose needs cannot be met in the hospital or the community.

This recommendation is under consideration. The Ministry's strategic policy paper, *Primary and Community Care in BC: A Strategic Policy Framework*, has identified the need to look at specific policy directions at the practice, organizational and provincial levels that would "systematically and opportunistically establish community and residential care services practices for patients with moderate to severe mental illnesses and/or substance use issues."

Work to support this goal will include exploring models of care that will meet the needs of patients with moderate to severe mental illness and/or substance use in order to create a more coherent and comprehensive set of services. The models are expected to build from current frameworks; however, they should be built as a community-based system of care and include health promotion and illness prevention activities, in contrast to the current fragmented service continuum.

Thank you for bringing these matters to my attention. It is my expectation that through our collaborative work with our Ministry partners, our health authority colleagues and the police, we can promote the health and safety of persons in correctional facilities, and help to prevent deaths of a similar nature from occurring.

Sincerely,

Terry Lake
Minister

pc: Mr. Doug Hughes, Assistant Deputy Minister, Health Services Policy and Quality Assurance Division, Ministry of Health

BRITISH
COLUMBIA

December 11, 2014
Ref: 505670

Ms. Lisa Lapointe, Chief Coroner
BC Coroner Services
Ministry of Public Safety and Solicitor General
Metrotower II
2035 – 4720 Kingsway
Burnaby BC V5H 4N2

Dear Mrs. Lapointe:

Your November 5, 2014 letter addressed to the Honourable Suzanne Anton, Attorney General and Minister of Justice regarding the jury's recommendations resulting from the Coroner's Inquest into the death of Mr. FAST (BCCS Case File #2013-0376-0134) has been forwarded to the Policing and Security Branch for response.

I am responding specifically to Jury recommendation #10: Review the practice of involving police in the ongoing care plans of hospital inpatients, which was also addressed to the Ministry of Health.

It is not within the purview of the Ministry of Justice, Policing and Security Branch (PSB) to review the policies of health-related entities as our mandate is inclusive of policing and law enforcement related policies. However, I would like to take this opportunity to inform you that the PSB, in partnership with the Ministry of Health and Vancouver Coastal Health Authority, has initiated a joint project to review integrated responses to persons experiencing a mental health and/or substance use crisis. The goal of the project is to provide clear and practical guidance to police agencies and mental health/substance use services on their respective roles and responsibilities when working together.

All of the information gathered throughout the duration of the project will culminate in the development of practical tools to support health authorities and police. More specifically, the tools will support the development of locally appropriate protocols with the intention of strengthening the interfaces between health authorities and police agencies across British Columbia.

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Ministry of Justice Policing and Security Branch Mailing Address: PO Box 9285 Stn Prov Govt Victoria BC V8W 9J7 Telephone: 250 387-1100 Facsimile: 250 356-7747 Website: www.gov.bc.ca/pssg

This is an important issue for public safety in British Columbia. Thank you for bringing this recommendation to my attention.

Yours truly,

Clayton J.D. Pecknold
Assistant Deputy Minister
and Director of Police Services
Policing and Security Branch

pc: Honourable Terry Lake, Minister of Health

BRITISH COLUMBIA

C503385
59100-20/FAST

September 29, 2015

Lisa Lapointe
Chief Coroner
BC Coroners Service
Metrotower II
Suite 800 – 4720 Kingsway Avenue
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Re: Coroner's inquest into the death of:
FAST, David Edwin
BCCS Case File #2013-0376-0134

Please find attached the completed response table that addresses jury recommendations arising from the coroner's inquest into the death of the above-named inmate at North Fraser Pretrial Centre.

As noted in the response table, outstanding recommendation #6 has been addressed with the completion of staff training by the contracted health service provider. All nine recommendations directed to the attention of the Corrections Branch have now been fully met.

The BC Corrections Branch strives to provide a safe and secure environment for incarcerated individuals. When tragedies such as this occur, the branch endeavours to modify and improve procedures to prevent similar occurrences.

Yours sincerely,

Brent Merchant
Assistant Deputy Minister

Attachment

pc: Dr. D. Kelly Barnard, Presiding Coroner

NORTH FRASER PRETRIAL CENTRE
DEATH OF INMATE – JULY 27, 2013

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
1. Obtain a formal external review of the quality of health care provided in provincial correctional institutions.	B.C. Corrections, the Ministry of Health and the Provincial Health Services Association have initiated a project to identify best practice in the provision of health care services in provincial correction facilities. The goal is to understand the clinical requirements of the inmate population, and to provide guidance to B.C. Corrections around appropriate clinical standards for care. These standards will support any future B.C. Corrections procurement process for health care services. A draft report outlining the quality of health care provided in provincial correctional centres has been completed.		**Completed**	
2. Institute a policy which states that all individuals being detained must be medically assessed by the local health authority or BC Ambulance Services prior to detention. Where such persons are found to require medications and ongoing medical treatment all efforts shall be made to have medical records released and accompany the individual to holding facility.	An initial health assessment (IHA) and a mental health screening (MHS) are conducted on all new intakes within 24 hours. This includes a review of PharmaNet to determine prescription history. Initial assessments include the ability for the assessor to initiate a number of formal protocols and work flows designed to manage critical inmate health care needs and information including withdrawal assessment, frequent monitoring, follow-up appointments, work orders and assessment reports. B.C. Corrections has on-going collaboration with our partners to ensure, where appropriate and authorized via the required legal frameworks, information sharing occurs across the various custody and health care		**Completed**	

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	agencies involved. Based on current legislative frameworks, the majority of information exchanged requires consent of the individual to share records.			
3. Institute a policy requiring the assessment and documentation of an inmate's ability to access water and food in the setting of their incarceration on intake and at least every 12 hours during their detention where there are indications of a disabling condition.	Currently, oral intake is provided regularly to inmates by correctional staff. Inmates with serious medical conditions will be placed on frequent monitoring as per policy and the health care manager will review the assessments and plans on a daily basis Health care staff, as well as correctional staff, monitor this intake, record it in CORNET and/or PAC, and adjust an inmate's health care needs and interventions according to this assessment. The appropriate use and review of frequent monitoring protocols will be reinforced with health care staff and qualified managers.		**Completed**	
4. Develop clear delineation of roles and responsibilities of correctional officers and contracted health care providers and the specific mechanisms for communication between them, including information sharing of any critical physical or mental health conditions.	Consideration of the privacy of inmates' information is always weighed against the "need to know" of the correctional staff. Health care staff are required by policy to enter a medical alert in CORNET for inmates with life threatening illnesses. Additional information is to be entered by nurses in the CORNET Client Log. Correctional staff are trained to review CORNET Alerts and Client		**Completed**	

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	Log entries.			
5. Implement mechanisms to immediately identify inmates with serious medical and or psychiatric problems so that they can be managed in a suitable setting.	These processes are already in place and include the inmate health assessment (IHA) and then subsequent discussions between the intake nurse, mental health screener and classification officer. A case conference approach is used to determine the health care and security needs of the individual, ensuring the appropriate placement in the correctional centre to meet the individual's ongoing safety and assessment needs.		**Completed**	
6. Ensure that the contracted health service provider confirms competence in all staff in the appropriate assessment, management and follow up of agitated inmates.	The health care contractor posted Non-Violent Crisis Intervention (NVCI) training modules on CorrPoint and directed all health care managers to ensure that all staff read and sign off the modules and keep a record in personnel files. As at September 28, 2015, all health care staff completed the NVCI training. The NVCI training is now part of the mandatory training for health care staff during their orientation.		**Completed**	

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
7. That any internal reviews of deaths in custody include examination of all records and interviews of all staff and contractors involved in the custody of the deceased inmate.	A critical incident review is held following the death of an inmate. The medical director, Corrections Branch, is consulted in the case of death by natural causes and advises whether a critical incident review is warranted. Corrections Branch policy requires a review of an in-custody death to include: interviews of witnesses; examination of relevant written statements, reports and related data; and, the inspection of areas or items of interest.		**Completed**	
8. Instruct BC Corrections that all records and statements pertaining to an inmate who dies in custody must be gathered and preserved until all proceedings have concluded.	Corrections Branch policy requires staff to submit detailed and accurate reports about the death of an inmate. Particular attention is paid to times and dates, names of witnesses, actions taken, identity of the person who last saw the deceased alive, and under what circumstances. Photographs or video recordings include details including location, time, subject matter, and name of the photographer. Records are maintained at the correctional centre where the death occurred until all proceedings have concluded. (Police, when called to investigate following an incident, may seize records (documents/property) that remain in their control and are not returned to the correctional centre.) Corrections Branch policy has been updated to ensure the retention of all available records		**Completed**	

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	related to an inmate death until all proceedings, including inquest, have concluded. Staff have been advised of this policy amendment.			
9. Explore providing health services in BC Corrections facilities through a Health Authority.	B.C. Corrections is conducting a review of health services in B.C.'s provincial correctional centres to ensure inmates' unique health care needs are met through the delivery of quality health services. Opportunities to explore other options for establishing the best health services delivery model will be pursued.		**Completed**	

Vancouver Coastal Health
Promoting wellness. Ensuring care.

12 December, 2014

Ms Lisa Lapointe, Chief Coroner
Province of British Columbia
Office of the Chief Coroner
Metrotower II
Suite 800 – 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

BCCS Case File # 2013-0376-0134

Thank you for your letter of September 24, 2014 to our CEO, enclosing recommendations from the inquest into the death of Mr. David Fast.

The Jury had made a number of recommendations to various agencies, including the health authorities. After having consulted with our operational and clinical leaders across the region on these recommendations, on behalf of Ms. Mary Ackenhusen I set out below our comment from Vancouver Coastal Health:

<u>To the Minister of Health and each of the Health Authorities:</u>

11. That guidelines and education on the application of the Adult Guardianship Act and the Mental Health Act be provided to all health practitioners whose responsibilities involve the care of vulnerable adults. This must include clear processes, including documentation for the initiation, continuation and discontinuation of the application of the provisions under these statutes. In particular, any person signing a certificate under these statutes must have directly assessed the patient, communicated the plans and, whenever possible, involved the family.

Coroners Comments:
Testimony was presented that there was much debate and some disagreement amongst care providers about the application of these legal provisions in the ongoing care of Mr. Fast. In particular the process for the cessation of the use of these was unclear. These deliberations included a Clinical Ethics consultation that focused on the needs of staff and did not involve direct communication with Mr. Fast or his family. The communication of the potential uses and implication of these legal restrictions to the patient and the family was not well documented.

VCH Comment:
VCH agrees that provincial guidelines for the application of Part 3 of the AGA would establish standards of practice and be beneficial to vulnerable adults requiring protection. A provincial guide on the application of AGA, Part 3, similar to the Guide to the Mental Health Act, or to the newly created Guide to the Certificate of Incapability Process under the Adult Guardianship Act would be a helpful resource for care providers.

VCH in 2005 developed the ReAct: Act on Adult Abuse and Neglect Manual and associated tools and job aids, accessible in hardcopy at every clinical operational unit in VCH and Providence Health Care. This ReAct practice guidance – the manual, posters, brochures and flow charts have been shared with all of the other regional health authorities and adapted for use nationally with populations with unique circumstances.

VCH has in place a tiered approach to education of all staff about the roles and responsibilities as Designated Agency. Each Community of Care in VCH has an identified resource with expertise for consultation on the Mental Health Act, the Adult Guardianship Act, and the other statutes providing a web of support fir vulnerable adults.

An Adult Protection Worker Curriculum has been developed, a standardized, comprehensive, competency based curriculum for authorized Designated Responders, staff who have responsibilities to receive and act on reports of suspected abuse, neglect and self-neglect. Developed in partnership with FHA, it has been shared with each health authority. All clinical new hires in VCH participate in Regional Online Orientation which includes a brief overview of VCH's role as a Designated Agency. Clinical staff who work with vulnerable populations are supported to take the online course "Act on Adult Abuse and Neglect: It's your duty!"
Clear communication with the affected adult and his / her family or other support system is a critical element of effective adult protection work, as with provision of health care generally.

12. Consider the implementation of a process to assign a continuing case manager for patients with complex medical and or psychiatric conditions whose care involves multiple services and providers and sites of care including the community.

Coroners Comments:
Many care providers and facilities were involved in Mr. Fast's case and there was insufficient coordination of these services, disrupting the necessary continuity of care and information required to provide safe care for Mr. Fast.

VCH Comment:
VCH agrees with this recommendation and has efforts underway in some areas to work toward this model (most notably in the Downtown East Side, and the 'Familiar Faces' project through Emergency and Primary Care). The identification of the most responsible provider will involve the case managers/care coordinators/Managers so that support may be customized to the individual client's needs.

13. Develop guidelines to ensure that whenever possible patients and families are directly involved in meetings regarding the planning of their care.

14. Require the completion, at monthly intervals and at discharge, of comprehensive accurate summaries covering the medical, social, and psychiatric needs of patients in hospital and the required plans for treatment and care. These documents must have sufficient information to safely manage ongoing care by any provider and should be available electronicaly in a timely fashion. In addtion, these should be shared with the patient or their substitute decision maker. In cases where a patient has been identified as vulnerable or medically fragile these summaries must be available immediately for access when the patient leaves the institution.

Coroners Comments:
The inquest heard that staff participated in many hours of discussion and case conferences regarding Mr. Fast. There were no specific records documenting or summarising these deliberations and none of the meetings directly involved Mr Fast, even after he was deemed a voluntary patient, competent to make his own discharge decision.

VCH Comment: (13 + 14):
As outlined in our *Partners in Care* document VCH agrees that "Quality care is best achieved when you, the patient/resident/client along with your family/friends, become "partners in care" with us, your health care providers."

Dialogue with the patient and / or family involved in the patient's care is a critical element of discharge planning. While the patient and/or family is not directly involved in all of the discussions concerning a discharge, and the documentation of those discussions is action oriented rather than comprehensively narrative, patients (and, if the patient agrees, families or other support system) are indeed involved in informing the discussions and planning discharge solutions. As the patient readies to return home, we supply a written document (My Discharge Plan) to the patient/care givers before discharge from hospital. We also provide a copy of the plan to the GP and our community partners, the transition services team (TST). The plan includes the name and contact information of the hospital physician; the reason the patient was hospitalized; tests and treatments performed; any follow-up tests or appointments; community health contact information and who to seek for additional medical care. For high-risk patients, we set up a visit with their GP within 48 hours of discharge. For moderate-risk patients who don't require a GP appointment within 48 hours, we'll check in with a phone call to ensure they are managing their care.

These recommendations are also being shared with the operations leaders and quality councils in each of our Communities of Care for consideration of further learning and system improvement.

15. In cases where a patient has been identified as having an unstable life threatening medical condition and they have discharged themselves against medical advice, every effort should be made by care staff to contact the patient, family, and other care providers and to follow up to ensure that care is available.

VCH Comment:
VCH agrees and expects that health care teams caring for patients who decide to discharge themselves against medical advice consider the patient's condition and ability to manage one's own safety, and take steps to assist the patient with the safest discharge possible. VCH is developing regional policy guidance and documentation concerning patients who leave against medical advice, which will emphasize the importance of contacting family, broadly defined, for patients leaving AMA about whom there is a concern for their capability and / or safety generally.

16. Explore the development of low-barrier long-term care facilities for patients with complex medical and or psychiatric conditions whose needs cannot be met in the hospital or the community.

Coroners Comments:
Many of the care providers involved in helping Mr. Fast to find suitable ongoing care testified that there are no facilities set up to deal with the patients who do not fit into existing programs due to their complex medical, psychiatric and behavioural needs.

VCH Comment:
Vancouver Coastal Health is in support of this recommendation, and is part of ongoing dialogue with our partners the Vancouver Police Department and BC Housing to explore the development and expansion of creative approaches to meet the supportive housing needs in our community.

Further, we have identified the Mental Health and Addictions population as one of our specialized populations, have provided unique programming and supports within some existing residential care sites for this population, and are exploring opportunities to enable access to these services for clients across VCH.

Sincerely,

J. Patrick O'Connor, MD, FRCPC
Vice President Medicine, Quality and Safety
VCH

Interior Health

Corporate Administration
Interior Health Authority
#220 – 1815 Kirschner Road
Kelowna, B.C. V1Y 4N7
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Dr. Robert Halpenny
President & Chief Executive Officer
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e-mail: robert.halpenny@interiorhealth.ca

February 16, 2015

Ms. Lisa Lapointe
Chief Coroner
Province of British Columbia
Suite 800-4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Re: Case File: #2013-0376-0134

In response to the recommendations issued as a result of an inquest into a death that occurred in New Westminster on July 27, 2013 Interior Health provides the following response:

Recommendation 11:
That guidelines and education on the application of the Adult Guardianship Act and the Mental Health Act be provided to all health practitioners whose responsibilities involve the care of vulnerable adults. This must include clear processes, including documentation for the initiation, continuation and discontinuation of the application of the provisions under these statutes. In particular, any person signing a certificate under these statues must have directly assessed the patient, communicated the plans and, whenever possible, involved the family.

Interior Health Response:
Due to legislative changes which came into force December 1, 2014 Interior Health has embarked on a plan for education on all aspects of the Adult Guardianship Act. This is a work in progress and will be implemented as resources are available.

Interior Health Internal Audit department conducted an audit of Interior Health's application of the Mental Health Act in 2013. Recommendations arising from this audit included development of a Clinical Decision Support Tool (CDST) for working with the Mental Health Act with subsequent education to healthcare providers on the CDST.

Recommendation 12:
Consider the implementation of a process to assign a continuing case manager for patients with complex medical and or psychiatric conditions whose care involves multiple services and providers and sites of care including the community.

Interior Health Response:
Complex medical and/or patients with a mental health disorder known to the community or referred to the community from acute and tertiary services receive a case manager in Interior

Health. In the case where psychiatric conditions dominate and the patient is referred to Community Mental Health Services a case manager is assigned. Improved service models linking these complex unattached patients with primary care are being implemented across the region. Services are being expanded around intensive case management which includes case finding services (locating clients in community that may choose to live at risk and are currently not attached to Community Mental Health Services) in larger centres in Interior Health. Where the predominant conditions are medical and there is a need for ongoing treatment in the community, a case manager is assigned through Home Health. As issues around mental health arise, the home health case manager will link back to Community Mental Health. Ongoing integration of these services will create a more integrated service delivery model.

Recommendation 13:
Develop guidelines to ensure that whenever possible patients and families are directly involved in meetings regarding the planning of their care.

Interior Health Response:
Patient and Family Centred Care (PFCC) which is about caring for patients through knowing their needs and values is a culture that is building within Interior Health. The Central Okanagan specifically is actively involved in ensuring PFCC is embedded in care at Kelowna General Hospital. Delivering patient and family centred care is one of Interior Health's strategic goals. Including the patient and family in meetings regarding the planning of their care would be aligned with the values of PFCC.

Interior Health's Patient Discharge Plan and Plan of Care both have guides which indicate the involvement of family and patient in identifying goals and ensuring they understand and are involved in the discharge arrangement. These forms were created primarily with the acute medical/surgical patient in mind. However, they are being reviewed by the inpatient mental health documentation group for their applicability with mental health and substance use patients. Both forms were originally created six months ago and all sites within Interior Health are to have them in use by March 31, 2015.

Recommendation 14:
Require the completion, at monthly intervals and at discharge, of comprehensive accurate summaries covering the medical, social, and psychiatric needs of patients in hospital and the required plans for treatment and care. These documents must have sufficient information to safely manage ongoing care by any provider and should be available electronically in a timely fashion. In addition, these should be shared with the patient or their substitute decision maker. In cases where a patient has been identified as vulnerable or medically fragile these summaries must be available immediately for access when the patient leaves the institution.

Interior Health Response:
All members of the Medical Staff are subject to an in-depth review prior to their appointment from the Provisional Medical Staff to the Active Medical Staff and every fifth year thereafter. As part of this review their documentation of both inpatient and outpatient clinical records is assessed for quality, accuracy and timeliness. The College of Physicians and Surgeons of British Columbia as well as the *Health Profession's Act* provide guidance to physicians on standards for documentation.

Health records would be shared with patients within the provisions of the *Freedom of Information and Protection of Privacy Act of British Columbia* and appropriate health authority policy.

Recommendation 15:
In cases where a patient has been identified as having an unstable life threatening medical condition and they have discharged themselves against medical advice, every effort should be made by care staff to contact the patient, family, and other care providers and to follow up to ensure that care is available.

Interior Health Response:
Interior Health will follow the provisions of the *Freedom of Information and Protection of Privacy Act* and notify family with patient consent and/or as the legislation allows specifically considering section 33.1 article(s) (m) and (n). Interior Health has also recently implemented Policy AH1060 Discharge of Vulnerable Emergency Department Patients which provides guidance to health care providers on action they must take when a patient is assessed as vulnerable upon discharge from the Emergency Department.

Recommendation 16:
Explore the development of low-barrier long-term care facilities for patients with complex medical and or psychiatric conditions whose needs cannot be met in the hospital or the community.

Interior Health Response:
Interior Health has previously responded to this recommendation through separate correspondence from Ms. Karen Bloemink, Executive Director for Residential Services for Interior Health dated November 28, 2014.

Thank you for the opportunity to review the results of the inquiry and determine the applicability of these recommendations for our Health Authority.

Sincerely,

Dr. Robert Halpenny
President & Chief Executive Officer

/vm

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island health

November 14, 2014

Ms. Lisa Lapointe
Chief Coroner
Metrotower II
Suite 800-4720 Kingsway
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

Re: Coroner's Recommendations: Coroner's Inquest into the death of Fast, David Edwin
Case No: 2013-0376-0134

Dr. Brendan Carr has asked that I reply to your request of September 24, 2014 for a response from Island Health to recommendations 11-16 of the Coroner's Inquest into the death of David Edwin Fast. I appreciate the opportunity to address these recommendations.

Recommendation 11: That guidelines and education on the application of the Adult Guardianship Act and the Mental Health Act be provided to all health practitioners whose responsibilities involve the care of vulnerable adults. This must include clear processes, including documentation for the initiation, continuation and discontinuation of the application of the provisions under these statutes. In particular, any person signing a certificate under these statutes must have directly assessed the patient, communicated the plans and, whenever possible, involved the family.

The Island Health Mental Health and Substance Use service (MHSU) Practice Resource team has created a Mental Health Act training module which has been provided to staff through in-person training and via DVD for 5 years. Approximately 2 years ago the course was moved to the Learning Management System (LMS) and is now accessible to all health authorities. In the spring of 2014 the MHSU Practice Resource Team created a safety hub on the Island Health intranet for the Mental Health Act. This hub provides links to forms, the Act and frequently asked questions and a list of the responsibilities of the staff and the physicians. This safety hub is available to all Island Health staff. The material for the safety hub and the online course was reviewed and approved by Gerrit Clements a legal expert on the legislation.

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A similar hub was created in the summer of 2014 for certificates of incapability and the upcoming changes to the Adult Guardianship Act. For upcoming legislative changes to AGA Part 2.1, education and training will be provided by the Ministry Of Health and by Island Health to all Health Authority Designates and Qualified Health Care Providers who assess and issue certificates of incapability.

Recommendation 12: Consider the implementation of a process to assign a continuing case manager for patients with complex medical and or psychiatric conditions whose care involves multiple services and providers and sites of care including the community.

Island Health has a well-established committee called *Hospital to Homes* which meets weekly to identify or develop community supports for inpatients with complex needs and who require the services of several different programs. Membership on the committee spans the service continuum and ranges from frontline staff to physicians to directors and executive. A lead is identified for each patient and the representatives from all needed service areas work together to develop innovative support packages. The lead ensures that a well-coordinated process is followed. The group is updated on status/barriers/successes on a weekly basis. Mental Health and Substance Use services has also recently (July 2014) hired a discharge navigator to help coordinate care for these individuals.

Recommendation 13: Develop guidelines to ensure that whenever possible patients and families are directly involved in meetings regarding the planning of their care.

The Psychiatric Emergency Service (PES) at RJH has recently developed a form to be completed by families which will provide staff information on the presenting concerns and prior relevant history of patients who present in the Emergency Department. This document will help ensure that family engagement occurs consistently and that all relevant collateral information is collected. The use of the form will compliment but not replace face to face interviews which will remain standard practice. On the inpatient units, family involvement is encouraged through meetings usually facilitated by the psychiatrist or the social worker. These meetings will remain standard practice and continue to be encouraged even during times of elevated activity and pressure.

One of the inpatient unit (RJH) actions associated with the MHSU services Strategic Plan is to provide family nursing education to the nursing staff so that they have the confidence and competence to work with families. This process is aided by the care plans, now used in several service areas that have an area to document social and family issues. MHSU Services will monitor the success of the use of the form and the education with a plan to generalize the learnings to all Island Health MHSU inpatient units.

Recommendation 14: Require the completion, at monthly intervals and at discharge, of comprehensive accurate summaries covering the medical, social, and psychiatric needs of patients in hospital and the required plans for treatment and care. These documents must have sufficient information to safely manage ongoing care by any provider and should be available electronically in a timely fashion. In addition, these should be shared with the patient or their substitute decision maker. In cases where a patient has been identified as vulnerable or medically fragile these summaries must be available immediately for access when the patient leaves the institution.

Island Health is engaged in a very ambitious system wide project to develop a comprehensive electronic health record. This initiative, in partnership with Cerner, will allow MHSU services to format systems to capture a broad range of clinical data in one accessible record for patients. This record will include updated clinical profile data based on the Health of the Nation Outcome Scales (HoNOS) along with risk indicators. Staff will be prompted when care plans and profiles need to be updated and all service providers will be able to access the information they need for continuity of care. There will be sections for the Mental Health Act and Adult Guardianship Act documentation. The first sites will go live with the new system in 2015.

Recommendation 15: In cases where a patient has been identified as having an unstable life threatening medical condition and they have discharged themselves against medical advice, every effort should be made by care staff to contact the patient, family, and other care providers and to follow up to ensure that care is available.

Part 3 of the Adult Guardianship Act allows health service staff to follow patients who have discharged themselves against the best interest of their own care. If there is concern about an adult's capacity to make choices, the AGA will be utilized to follow up. The follow up will often take the form of an urgent referral to appropriate Island health community setting/service such as Seniors Health, MHSU, Home and Community Care. More generally, inpatient units and emergency departments frequently involve community crisis response teams or case management teams to follow up with patients who are at risk and discharge themselves against medical advice.

Island Health MHSU is also in the process of creating a new discharge policy intended to be used at all MHSU inpatient services across the region. The draft policy will provide direction on how to respond when patients discharges themselves against medical advice.

Recommendation 16: Explore the development of low-barrier long-term care facilities for patients with complex medical and or psychiatric conditions whose needs cannot be met in the hospital or the community.

Over the past year, island Health Directors have met to discuss ways to better serve a 'gap' population whose needs are not well met by existing services. These discussions have resulted

in a proposal being issued to the Ministry of Health to help fund a Transitional Mental Health Facility. This facility will have the capability to serve a broad population with co-occurring mental health, physical health and behavioral issues and that don't meet the criteria for traditional/existing facilities. The facility funding has been confirmed and a site identified with an opening date projected for March 2015.

Other work is occurring, through a director lead working group, to help make seniors long-term care facilities more able to serve a broader population with mental health issues. This will be accomplished by making psychiatry and other MHSU services easily available to these facilities when needed.

Thank you again for the opportunity to respond to your recommendations. Please let me know if you have any questions or concerns.

Sincerely,

Dr. Taj Baidwan
Executive Vice-President & Chief Medical Officer

cc. Dr. Brendan Carr, President & CEO
Dr. Richard Crow, Executive Medical Director, Adult Mental Health & Addiction Services, Public Health & Child/Youth & Family Health
Cheryl Damstetter, Executive Director, Adult Mental health & Addiction Services, Public Health & Child/Youth & Family Health

fraserhealth

November 21, 2014

Lisa Lapointe
Chief Coroner
BC Coroners Service
Metrotower II,
Suite 800 – 4720 Kingsway
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

Re: Coroner's Inquest into the death of: FAST, David Edwin
BCCS Case File #2013-0376-0134

Thank you for your letter of September 24th, 2014 requesting a response and plan of action regarding the jury recommendations to Fraser Health.

We have carefully considered the jury's recommendations and provide the following response.

Recommendation 11: That guidelines and education on the application of the Adult Guardianship Act and the Mental Health Act be provided to all health practitioners whose responsibilities involve the care of vulnerable adults. This must include clear processes, including documentation for the initiation, continuation and discontinuation of the application of the provisions under these statutes. In particular, any person signing a certificate under these statutes must have directly assessed the patient, communicated the plans and, whenever possible, involved the family.

Fraser Health has had regional Policies and Procedures regarding the *Mental Health Act* for several years. These are available on the Fraser Health Intranet for all staff and physicians to access. This includes a policy and procedure regarding Rights Advice and Notification of Near Relative.

Practice support regarding the *Mental Health Act* is readily available to all Fraser Health staff and physicians through the "Mental Health Act Resource Network (MHARN)." The purpose of this network is to provide ongoing education, consultation, and support to front line Mental Health and Substance Use clinicians in Fraser Health with respect to the Mental Health Act and the use of the extended leave provisions. Education, consultation, and support are carried out with a view toward developing best practices.

Fraser Health is in agreement with the jury's recommendation with respect to Part 3 of the *Adult Guardianship Act*. Fraser Health looks forward to working with the Ministry of Health and the other Health Authorities to develop mandatory provincial standards which outline clear processes and requirements for the application of the provisions under Part 3 of the *Adult Guardianship Act.* This work will need to review

the Health Authorities' statutory requirements under both the *Adult Guardianship Act* and the *Mental Health Act* as they apply to the provision of care to vulnerable adults.

Fraser Health will continue to recommend that all staff whose responsibilities involve the care of vulnerable adults take the Fraser Health online education module on Adult Abuse & Neglect. We will also look for opportunities to deliver the Re:act Curriculum to our Designated Responders. Fraser Health's Clinical Specialist, Adult Abuse & Neglect is available to provide consultation and recommendations to all of our staff on the interpretation and application of Part 3 of the *Adult Guardianship Act* in complex clinical cases which involve vulnerable adults.

Recommendation 12: Consider the implementation of a process to assign a continuing case manager for patients with complex medical and or psychiatric conditions whose care involves multiple services and providers and sites of care including the community.

Fraser Health has implemented a care plan indicator project attempting to provide consistent care to patients who seek emergency care at any Fraser Health site more than 20 times per year. This work is lead by the Emergency program that has identified 500 plus patients who meet these criteria. Most of these patients have complex co-morbidities and are mobile between hospital sites and community services.

Fraser Health will also be implementing a revised Complex Patient Discharge or Transfer to Alternate Service Environment Policy. This policy will incorporate new tools to assist teams with managing complex patient discharges. The new tools include a check-list, more robust expectations on documentation, letter templates and algorithms. Patients with complex discharge needs can be put on the Complex Patient Discharge tracker. This captures next steps / accountabilities related to planning services to support the patient's transfer from hospital.

While the Health Authority recognizes that continuity of care can be a challenge for complex individuals who receive service at multiple sites, at this time Fraser Health does not have the ability to assign individual case managers for this cohort of patients. However, by implementing the measure above we are creating mechanisms and processes to assist in improving and ensuring continuity for those patients who seek care across services and sites.

Recommendation 13: Develop guidelines to ensure that whenever possible patients and families are directly involved in meetings regarding the planning of their care.

Fraser Health has commenced work on a system-wide patient and family centered care initiative where "The patient and family is at the heart of every decision: empowered to be equal partners in their care with their needs, preferences, and cultural beliefs valued". Patient and family engagement will occur more robustly over time at the individual, organizational and system level. Individual level means that patients and families will be partners in care at bedside and in multidisciplinary meetings related to their care and transitions.

The Patient Advisory Council is stewarding this as well as a structure and process for supporting and mentoring patient advisors in their roles at each level of involvement with Fraser Health.

Recommendation 14: Require the completion, at monthly intervals and at discharge, of comprehensive accurate summaries covering the medical, social, and psychiatric needs of patients in hospital and the required plans for treatment and care. These documents must have sufficient information to safely manage ongoing care by any provider and should be available electronically in a timely fashion. In addition, these should be shared with the patient or their substitute decision maker. In cases where a patient has been identified as vulnerable or medically fragile these summaries must be available immediately for access when the patient leaves the institution.

Following careful consideration Fraser Health rejects the recommendation of completing a comprehensive summary at monthly intervals. Professional documentation standards exist in Fraser Health and with regulatory bodies. Fraser Health staff and physicians are expected to follow these standards when providing care to patients. A discharge summary is required by the most responsible physicians for all patients. There are several key areas for clinical documentation, most notably the patient's paper based or electronic chart/heath record. The newly created policy Complex Patient Discharge or Transfer to an Alternate Service Environment outlines the expectation of documenting issues/finding related to care. Fraser Health will investigate the need for a standard template/documentation process for discussions and actions from case conferences for complex patient discharges.

Recommendation 15: In cases where a patient has been identified as having an unstable life threatening medical condition and they have discharged themselves against medical advice, every effort should be made by care staff to contact the patient, family, and other care providers and to follow up to ensure that care is available.

Fraser Health must comply with provincial legislation including the *Health Care (Consent) and Care Facility (Admission) Act* and Regulations. This Act states that every capable person has the right to give, refuse or withdraw consent on any grounds even if refusal will result in death. In British Columbia every person is presumed capable of making decisions about their health care until the contrary is demonstrated.

It is not appropriate for the healthcare team to override the patient's decision by contacting the family, other care providers or other individuals to ensure care is available. This would both violate the patient's right to decide to live at risk and contravene our statutory requirements under the *Adult Guardianship Act* and the *Freedom of Information and Protection of Privacy Act.*

However, Fraser Health is reviewing its policies and guidelines to support staff in determining when it is appropriate to intervene if a vulnerable patient chooses to leave the hospital against medical advice. This will include utilizing appropriate tools such as the *Adult Guardianship Act* to determine when it is appropriate to inform next of kin or a substitute decision maker.

If a voluntary psychiatric patient leaves a psychiatric unit and is considered to be a danger to themselves or others the police are contacted to apprehend the patient under Section 28 of the *Mental Health Act* and

transport them to a health facility. If a certified psychiatric patient leaves without physician approval the police a warrant is issued to authorize the police to return the patient to hospital. The patient's next of kin are also be notified.

Recommendation 16: Explore the development of low-barrier long-term care facilities for patients with complex medical and or psychiatric conditions whose needs cannot be met in the hospital or the community.

Fraser Health is exploring the development of a low-barrier facility or facilities that can accommodate patients with complex medical, psychiatric and behavioural issues. To this end, Fraser Health has committed resources to hire a new Housing Leader position to explore partnerships with BC Housing, Municipalities, and third party providers to meet this need.

Fraser Health welcomes feedback and recommendations from all sources that enables us to improve the services we provide to individuals and families. We have carefully considered the jury recommendations and the presiding Coroner's comments in order that we plan and implement practical improvements consistent with the spirit of the recommendations.

If you have any questions, please do not hesitate to contact us.

Sincerely,

Michelle Allen
Coroners Liaison, Integrated Risk Management

cc: Lois Dixon, Vice President, Clinical Operations
Vivian Giglio, Vice President, Clinical Operations