BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2011-0364-0054

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

in the Province of British Columbia, on the following dates December 3, 4 and 5th, 2012

before Mr. Vincent Stancato, Presiding Coroner,

into the death of REED, Patricia Donna (Last Name, First Name Middle Name) 59 (Age) ☐ Male ☒ Female

and the following findings were made:

Date and Time of Death: February 9, 2011 in the PM hours

Place of Death: Riverview Hospital (Location) Coquitlam, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Cold Exposure

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

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 5th day of December AD, 2012.

Vincent Stancato
Presiding Coroner's Printed Name

Presiding Coroner's Signature

REED	PATRICIA DONNA
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Vincent M. Stancato
Inquest Counsel: Mr. Rodrick MacKenzie
Counsel/Participants: Mr. Adam Howden-Duke, Counsel for the Provincial Health Services Authority
Ms. Cheryl Khanna, Counsel for Dr. Michael Dowey, Psychiatrist

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 8 exhibits as entered. Nineteen witnesses were duly sworn and testified.

PRESIDING CORONER'S SUMMARY:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided 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.

At approximately 14:30 hours on February 14, 2011, a patient walking the grounds at Riverview Hospital discovered an unresponsive female, later identified as Ms. Patricia Donna Reed. Ms. Reed was a patient at Riverview Hospital who was reported missing five days earlier on February 9, 2011. Ms. Reed's body was found lying in a shallow ditch near a decommissioned gravel road between the Brookside Building and Lougheed Highway, a short distance from the Centre Lawn Building (Ward E2) where she had been residing. Security staff attended the scene immediately. Resuscitation was not attempted as Ms. Reed was obviously deceased.

At approximately 14:49 hours, police attended the Riverview Hospital grounds and secured the scene. The attending police officers testified that they found Ms. Reed's body face down, lying in a ditch. The Coroner attended and examined Ms. Reed in situ and was able to confirm that she had not been moved from this position post death. There appeared to be no trauma to her body or any indication of foul play. Of note, there was a pair of shoes, a red jacket and a sling lying on the ground near Ms. Reed's body. These items were confirmed as belonging to Ms. Reed and the significance of their removal from her body is important when considering the cause of death. A phenomenon known as "paradoxical undressing" is often associated with individuals suffering from cold exposure or hypothermia. Ms. Reed's body was transported to Royal Columbian Hospital for autopsy.

An autopsy was conducted by Dr. Craig Litwin at Royal Columbian Hospital who testified that Ms. Reed's cause of death was due to Cold Exposure. He noted that this determination was made by ruling out natural disease and intoxication while at the same time considering several key indications of hypothermia including: paradoxical undressing (removal of clothing from body), petechial hemorrhages on the gastric mucosa, superficial injuries associated with disorientation/confusion and ambient temperature at the time of her disappearance (wet and cold).

The inquest proceedings primarily focused on the actions of the various parties involved in the five day period from Ms. Reed's disappearance to her discovery. The key areas of examination are reviewed below and included the circumstances surrounding her disappearance; internal communication; the nature and extent of the subsequent search by Riverview staff, police and security; and, the policies and practices related to missing persons that were in effect at Riverview Hospital at the time.

The jury heard that Ms. Reed was last seen alive by nursing staff on February 9, 2011 between 11:00 - 11:30 hours. Ms. Reed had left the ward at that time on an authorized two hour unescorted leave. Ms. Reed had full ground privileges, but she was not permitted to go off site. Riverview staff testified that Ms. Reed did not sign out for her leave that day and that the sign in/sign out process was generally unmonitored. Ms. Reed was scheduled to return at approximately 13:30 hours but had not. At 13:30 hours, Ms. Reed's spouse came to the ward looking for Ms. Reed and it was at this time that staff was alerted to the fact she had not returned and her whereabouts were unknown. An immediate building search by nursing staff commenced which yielded negative results.

At approximately 14:30 hours on February 9, 2011, Riverview Hospital grounds staff were notified and asked to search the surrounding areas of the building. This search was also unsuccessful which prompted the on-call psychiatrist to issue a warrant at 17:02 hours. Later that evening, nursing staff contacted the Coquitlam RCMP and the RCMP indicated that they were already aware that a warrant had been issued. Nursing staff noted their heightened concern regarding Ms. Reed's whereabouts and a police officer was subsequently dispatched to Riverview Hospital at 20:00 hours. The officer was able to collect general information about Ms. Reed and her tendencies while on unescorted leave as well as a physical description. The officer testified that he arranged for Air 1 to conduct an aerial search of the Riverview Grounds that evening with the use of infrared technology while he conducted a ground search in his vehicle. This search was also unsuccessful. A high degree of faith was put into the negative results of the Air 1 infrared search to the point where staff believed that because she was not found during that search she was most likely off site.

In the days following Ms. Reed's disappearance communication between Riverview Hospital and the Coquitlam RCMP was limited. There was no arrangement for a follow up day time search of the grounds that included the police.

The Riverview grounds are also monitored by Paladin Security who was first informed of Ms. Reed's disappearance at 22:00 hours on February 9, 2011. At the time, they were briefed on the circumstances and current status (results of ground & police searches) of Ms. Reed's disappearance and advised to "keep an eye out for her". Following receipt of this report, security officers actively looked for Ms. Reed throughout the evening and early morning hours with no success. It is important to note that a CODE YELLOW (Stage 3 Search – detailed search room by room, search of every building, building perimeter and entire hospital grounds) was not initiated at this time. There was no contact between hospital management and Paladin Security on February 10th regarding Ms. Reed. On February 11th at 12:33 hours the Paladin Security site supervisor received an email from the Clinical Services Manager in Charge of Ward E2 indicating that Ms. Reed was still missing and requested a search of the East Lawn and Crease buildings. This search yielded negative results.

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On February 12th at 13:30 hours the Director On-Call and On-Call Manager contacted Paladin Security and activated a CODE YELLOW for Ms. Reed. Having been alerted to the request by his staff, the Client Services Manager at Paladin Security contacted the On-Call Manager at Riverview Hospital to inquire about bringing in additional staff to complete the extensive search in a timely manner but the On-Call Manager stated that it was not necessary to do so. From 13:30 to 21:30 hours, security officers searched every building and the entire grounds but were unsuccessful in locating Ms. Reed. Security Officers continued searching for Ms. Reed during their regular patrols on February 13th and up to the point that she was found by a patient walking the grounds on February 14th at approximately 14:30 hours.

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Pursuant to Section 38 of the Coroners 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: Provincial Health Authorities
Ministry of Health

1. That the Provincial Health Authorities and the Ministry of Health review this Verdict and ensure processes are in place for a coordinated response to persons that are identified as being on unexcused absence. To be most effective, this approach must have a designated response coordinator such that the activities of the various involved parties (including hospital staff, police and contracted security) are coordinated.

Presiding Coroners Comment:

The jury heard that various searches were conducted by staff, police and Paladin Security throughout the course of Ms. Reed's disappearance. The evidence at the inquest clearly revealed that despite the involvement of these parties there was no coordinated approach to share information and update each other from the time Ms. Reed disappeared until she was discovered. At no time was any one individual designated as a coordinator of information. The result was an overall lack of communication among the multiple parties involved and, as such, they were all working with limited and different information. The jury also heard from several witnesses (staff & security) who were aware that Ms. Reed was still missing but unaware of the status of the search or who was leading it. Many presumed that the police and Paladin Security were coordinating an ongoing search which was not the case.

2. That the Provincial Health Authorities and the Ministry of Health review current practices respecting sign out privileges for involuntary psychiatric patients to ensure that only those with permission are able to exit the facility. A mechanism to manage such privileges must be in real time and constantly updated. This could involve the use of swipe cards, camera's, and/or GPS technology.

Presiding Coroners Comment:

The Jury heard that Ms. Reed was classified as low risk for elopement and was granted Level 3 Activity clearance which meant that she had the ability to make safe and responsible use of the hospital grounds and facilities (outside of the ward). She was able to do so un-escorted two times per day for up to two hours. The jury heard that the hospital used a logbook to manage patient in/out privileges and that the process was not supervised and relied simply on the patient signing themselves out. There was no assessment on the patient's particular mental or physical health status in advance of the leave and no formal way to monitor if they returned safely and on time. The jury also heard from Dr. Dowey who specifically testified that patient elopement was a significant problem at Riverview and there was a need for a more precise method/system of monitoring leave status.

3. That Provincial Health Authorities responsible for the delivery of services to Mental Health patients review their own current policies and seriously consider adopting the new CODE YELLOW policy developed by the Provincial Health Services Authority in August 2011. Of course, patient population and site configuration would need to be considered in order to tailor the CODE YELLOW policy to the specific location.

Presiding Coroners Comment:

The jury heard that Riverview Hospital policy provides for the ability to initiate a CODE YELLOW in instances where there is a significant degree of risk to and concern about a missing person. The jury heard that a CODE YELLOW was not initiated until February 12, 2011 - three days following Ms. Reed's disappearance, despite the fact that she was at risk based on her mental health status and exposure to elements at this time of the year. The Jury heard that the CODE YELLOW policy employed by Riverview Hospital involved a three stage approach. Stage 1 and 2 involve specific and targeted searches. It is not until Stage 3 is reached that a full blown, detailed search of the entire grounds and buildings is conducted and that can sometimes be too late. The jury also heard that the Provincial Health Services Authority developed a new policy around activating a CODE YELLOW and that this new policy may work for Riverview Hospital if tailored appropriately.

4. That the Provincial Health Authorities and the Ministry of Health ensure policies and procedures be reviewed at a minimum, on an annual basis, and signed by all employees. These procedures should be tested on an annual basis. Management is responsible for following up to ensure that all employees have reviewed and understand these procedures.

Presiding Coroners Comment:

The jury heard testimony by Riverview staff that there is currently no requirement for regular review and in-service regarding policy and procedures, specifically with respect to in/out privileges, missing persons and CODE YELLOW.

5. That the Provincial Health Authorities and the Ministry of Health Risk Managers or their equivalent from different facilities, meet on an annual basis to review their policies, procedures and sharing of best practices.

Presiding Coroners Comment:

Self explanatory.