BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.:2010:1007:0110

An Inquest was held at Western Communities Courthouse, in the municipality of Colwood

in the Province of British Columbia, on the following dates December 12-16, 2011

before Matthew Brown, Presiding Coroner,

into the death of KOZELETSKI Hayden Blair 16 ☐ Male ☒ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: December 19, 2010 at 1956 hours

Place of Death: 2400 Arbutus Road Victoria, British Columbia
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death:	a) Acute Asphyxiation
	DUE TO OR AS A CONSEQUENCE OF
Antecedent Cause if any:	b) Hanging by the neck
	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:	Depression with suicidal ideas

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

The above verdict certified by the Jury on the 16th day of December AD, 2011.

Matthew Brown
Presiding Coroner's Printed Name

Presiding Coroner's Signature

VERDICT AT INQUEST

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

FILE NO.: 2010-1007-0110

KOZELETSKI	HAYDEN BLAIR
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Matthew Brown
Inquest Counsel: John Orr
Court Reporting/Recording Agency: Verbatim Words West Ltd.
Participants/Counsel: Ministry of Children and Family Development/Richard Meyer, Robert Bush/Counsel for family, Penny Washington/Vancouver Island Health Authority and David Pilley/Counsel for Dr. Peggy Firstbrook, Dr. Colin Bullock and Dr. Gunther Klein.

The Sheriff took charge of the jury and recorded 18 exhibits. 31 witnesses were duly sworn 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.

The jury heard evidence that Hayden Blair Kozeletski had been a patient at Ledger House in Victoria British Columbia from the time of her admission on October 28, 2010 until her death. Ledger House is a tertiary care hospital within Queen Alexandra Hospital that provides short term placement and residential assessment for children and youth with mental health issues.

Prior to her admission to Ledger House, Hayden had been struggling with an acute episode of emotional turmoil with clinically significant symptoms of emotional distress, including anxiety, hyper vigilance, depression, anger, low self esteem and chronic suicidal ideation. Her first hospitalization occurred early October 7, 2010 when she was brought to the hospital by her teacher for anxiety and panic symptoms. In and around this time, it became known that Hayden had disclosed sexual abuse by a family member. At the time, the Ministry of Children and Family Development (MCFD) interviewed Hayden as a result of the disclosure. On October 14, 2010, Hayden referred herself to the hospital once again as a result of feeling overwhelmed and anxious.

The jury heard that Hayden had a two-month history of major depressive episodes on a background of allegations of sexual abuse over a six-year time span. Hayden described feeling a loss of control and chaos in her life. During the visit, Hayden was certified under the Mental Health Act and kept on the adult psychiatric unit at St. Joseph's General Hospital in Comox. She was diagnosed with major depressive disorder, substance abuse disorder, anxiety disorder (not otherwise specified – NOS) with several stressors in her life including unexpected contact with the alleged abuser, disclosure of sexual abuse and subsequent action involving MCFD and the police.

She remained at St. Joseph's Hospital until October 18, 2010 at which time she returned to her parents' home. Her course in hospital had been marked by some social isolation and fear of older patients; however her mood had improved somewhat, and a referral had been made for Hayden to see a mental health clinician with the Child, Youth Mental Health team in the next one to two days. Her diagnosis upon discharge was major depressive disorder with stressors related to recent disclosure of sexual abuse.

On October 24, 2010, Hayden was admitted to Campbell River General Hospital for suicidal ideation. She was found in the woods carrying a rope with the plan to hang herself.

She was certified and remained in hospital under one-to-one nursing care until she was eventually transferred by ambulance to Ledger House on October 28.

Upon assessment at Ledger House, Hayden presented with concerns related to chronic suicidal ideation and attempts in the context of post traumatic stress disorder. She had been previously certified under the Mental Health Act at Campbell River General Hospital but certification had lapsed. She was not re-certified by the admitting psychiatrist at the time of her admission to Ledger House and spent several days on the Special Care Unit (SCU) and was then moved to the Youth Unit (YU) after it was determined she was stable.

Between October 28 and mid December 2010, Hayden remained at Ledger House and returned home for several weekend visits. During her hospitalization, she worked with staff on areas such as self esteem, coping strategies, communication, etc and this occurred through work with the social worker, art therapy, the psychiatrist and group work. As discussions turned to discharging Hayden, her anxiety increased along with her suicidal ideations.

On December 15, 2010, a meeting was held prior to Hayden returning home for a weekend pass. During this meeting, Hayden's ambivalence increased to the extent that she left the meeting and was found curled up in the bathtub in her room after the topic of long term planning had come up. Hayden's mother gathered Hayden from the bathroom and the family left and drove home to Campbell River for the weekend visit.

On the evening of December 18, Hayden went to a friend's house on a pre-arranged visit with the intention of staying overnight. Over the course of the night, Hayden became anxious. She took medication to help decrease the anxiety without success and Hayden and her friend walked to the hospital to seek treatment. She was brought into the emergency room where she was seen by both a nurse and then physician in the rapid assessment room. Hayden's friend testified that Hayden spoke about suicide over the course of their evening, that her plan was to hang herself and that this had been her plan for some time.

The jury heard evidence that Hayden was seen by a nurse and then the emergency physician. During the course of these conversations, both testified they became aware of Hayden's recent mental health history. Hayden admitted to drinking alcohol and smoking marijuana during the course of the evening. Hayden said she did not have an active suicidal plan but this information was not documented in the medical records. Hayden was prescribed Ativan for her anxiety and remained in hospital through the night. The physician testified that he became aware that Hayden was on a weekend pass from Ledger House and that the plan was for Hayden to return there the following day. A nurse at the hospital contacted Ledger House to advise them of the hospital admission. Hayden was not certified as she demonstrated insight and did not appear to have an active suicide plan though she was considered to be at a moderate risk for suicide.

The jury heard evidence that there is no psychiatrist on call during the evening shift and the only avenue to see a psychiatrist is to be transferred to an in-patient bed. Further, the jury heard that Hayden had seen a crisis nurse in the past when she attended Campbell River General Hospital; however, the crisis nurse finished shift at 1930 hours and there was no crisis nurse available until the following morning at 0930 hours. The jury heard that Hayden told the hospital staff that she would hang herself before she was discharged from Ledger House; however, this was not documented in records and it's not clear if it was shared with Ledger House staff.

There was no contact between the hospital and Hayden's family during the hospital admission until the following morning when she was released to the care of her parents and the family drove to Victoria with the plan of

returning Hayden to Ledger House. Evidence provided by family members and friends revealed that Hayden was hyperactive, laughing out of context and free associating while verbalizing her thoughts. She could not stand up on her own and reported to not feel well. Hayden told her family that she was given Ativan while in the hospital.

A staff member on day shift at Ledger House gave evidence that he received a call from Campbell River General Hospital advising them of Hayden's admission the previous night. He reported that she was "distressed, emotionally upset and unstable" during her admission and was given Ativan to help calm her down. He was under the impression that Hayden would remain in hospital given her condition and her statement that she would jump out of the moving vehicle if transported. A second call was made to Campbell River General Hospital by Ledger House at which time they were advised that Hayden had been discharged and was on route to Victoria. Given this, the staff member assumed that Hayden was stable. His shift finished at 1530 hours that day.

Evidence presented at the inquest revealed that Hayden and her family arrived at Ledger House between 1615 and 1635 hours and were met by staff members with whom they were unfamiliar. One of the staff members attended to Hayden personally upon her return. She described Hayden as giggling and laughing and that at one point, she stood against the wall and fell to the floor, prompting the staff person to lift her back up. She said that Hayden couldn't tie up her pants. The staff person reported never seeing Hayden like this before. She completed a search of Hayden's belongings and found a knife which she confiscated.

She gave evidence that she spoke with the dayshift staff member and her understanding was that Hayden had checked herself into the hospital after drinking with friends and was then discharged to her parents the following morning. She gave evidence that she heard that Hayden had said she would jump out of the car. The staff member stated that she monitored Hayden's behaviors and that she was focused on the mental status assessment of Hayden and did not recall speaking with Hayden's parents during this period of time.

Hayden's parents left Ledger House a short time later and she was encouraged to go to the common area. When the supper meal arrived staff observed Hayden get up and move to her room and when they went to check on her a short time later, she was not there. A building and grounds search was initiated but Hayden was not found.

Hayden's parents were notified at approximately 1730 hours followed by the police (non emergency line) thereafter. Family members testified that they turned around and headed back to Victoria. A family member testified that several phone calls were made to the facility with the suggestion that Hayden likely went to the beach. The family arrived at the facility at approximately 1850 hours and Hayden's father went to search for Hayden. Approximately ten minutes later, he found Hayden hanging from a tree on the beach. He called Ledger House, cut Hayden down and began cardiopulmonary resuscitation (CPR). 911 was called by Ledger House staff and police, fire department and the BC Ambulance Service were dispatched to the area however, due to the remote location, they did not arrive on scene until approximately 1930 hours. Despite exhaustive efforts to resuscitate Hayden, her death was pronounced at the scene.

The jury heard evidence that following Hayden's death, several reviews were conducted. These included reviews undertaken by the Vancouver Island Health Authority (VIHA), Saanich Police Department and the Ministry of Children and Family Development (MCFD). Recommendations followed from each review and the jury heard that implementation varied among the agencies. A final summary completed by the psychiatrist at Queen Alexandra Hospital revealed a final diagnosis of dysthymia (mood disorder), Anxiety Disorder (NOS) and substance misuse (alcohol, marijuana).

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: Minister of Education
Province of British Columbia
Room 310 - Parliament Buildings
Victoria BC V8V 1X4

1. That middle school and high school counselors province wide will have ongoing up to date suicide awareness training. Further, that documentation be completed if suicide risk factors are identified.

   Coroner's comments: *The jury heard evidence that suicide awareness training was not required on an ongoing basis for high school counselors and that there are no school board policies to guide staff on when and how training should be devised. Furthermore, the jury heard evidence that there are no requirements or policies to document conversations where children or youth are at risk for suicide.*

2. That the Ministry of Education provide a provincial standard of risk assessment and mental status examinations for school boards across British Columbia to ensure that there is consistent practice, assessment and tools for school counselors when working with children and youth at risk.

   Coroner's comments: *The jury heard evidence that there is no province-wide standardized risk assessment tool or mental status examinations to guide school counselors when working with children and youth at risk.*

To: Minister of Education
Province of British Columbia
Room 310 - Parliament Buildings
Victoria BC V8V 1X4

Minister of Children & Family Development
Province of British Columbia
Room 236 - Parliament Buildings
Victoria BC V8V 1X4

Minister of Health
Province of British Columbia
Room 337 - Parliament Buildings
Victoria BC V8V 1X4

3. That an inter-ministerial liaison be appointed to assist families in navigating the mental health system in British Columbia.

   Coroner's comments: *The jury heard evidence that when Hayden began to demonstrate emotional distress in conjunction with her sexual abuse disclosure, several agencies became involved with the family which caused confusion for the family. The agencies had mandates which were in some ways similar but dissimilar and it became unclear for the family as to who was there to help Hayden and how.*

4. That standardized in-service training and professional development on suicide risk assessment and prevention is provided to all staff who have interactions with children and youth within the Ministry of Health, Children and Family Development and Education.

   Coroner's comments: *The jury heard evidence that there is limited co-education between the three Ministries who work with at-risk children and youth and that a coordinated effort with training, would help to guide the agencies, share information and provide a seamless level of service for children and youth.*

To: Minister of Health
Province of British Columbia
Room 337 - Parliament Buildings
Victoria BC V8V 1X4

5. That a standardized suicide risk assessment be conducted for all patients arriving in the Emergency Room presenting with suicidal ideation and, if deemed at risk, be appropriately supervised.

   Coroner's comments: *Then jury heard considerable evidence on the topic of suicide risk assessment during the inquest. In doing so, several models of suicide risk assessment were shared, all with the caveat that suicide risk assessment is an ongoing process of assessment rather than a 'one-time only' occurrence.*

6. That the Ministry of Health fund 2 beds specifically for adolescent patients at St. Joseph's Hospital in Comox and/North Island replacement hospital.

   Coroner's comments: *The jury heard evidence that when placed in the psychiatric unit at St. Joseph's Hospital in Comox, Hayden was with adults which caused undue stress and worry on her part. Evidence was presented that a new hospital was in development for the North Island area.*

7. That Province wide electronic charting (power chart or equivalent) be implemented in all medical facilities.

   Coroner's comments: *The jury heard that St. Joseph's Hospital and Queen Alexandra Hospital do not have access to electronic charting which would allow staff in each facility to review records on a patient seen at another hospital on a real-time basis.*

8. That the files of patients with a history of suicidal ideations be flagged.

   Coroner's comments: *The jury heard evidence that there is no flagging system on electronic or hard copy files that would assist in heightening the response by hospital staff to a patient upon arrival at hospital.*

9. That the Mental Health Act be amended to remove the automatic expiry of certification upon the passage of 48 hours.

   Coroner's comments: *The jury heard evidence that Hayden's certification under the Mental Health Act was not renewed between her discharge from Campbell River General Hospital and Ledger House.*

To: Dr. Brendan Carr
A/President and Chief Executive Officer
Vancouver Island Health Authority
1952 Bay Street
Victoria BC V8R 1J8

10. That an automated external defibrillator device (AED) be a mandatory item of equipment on the Ledger House and Queen Alexandra site/facility and that staff are trained on its use and application. Further, that emergency kit with flares be available to all staff at both sites.

    Coroner's comments: *The jury heard evidence that in the event of a medical event of a patient or staff person, there is no automated external defibrillator device (AED) to assist if someone goes into cardiac arrest. Furthermore, the jury heard that the Queen Alexandra grounds are vast and dark with very limited cellular phone coverage making successful searches challenging.*

11. That directives be provided to all staff to ensure that prior to discharge of a child or youth from hospital where they have been assessed for mental health issues, a formal meeting occurs with the parent or guardian to ensure the seamless transfer of information with respect to the child or youth's mental health status and further planning.

    Coroner's comments: *The jury heard evidence that upon discharge from Campbell River General Hospital on the morning of October 18, 2010, there was no formal discussion between Hayden's family and hospital staff to ensure they had an accurate picture of the reasons for Hayden's admission the evening before and considerations during the transport from Campbell River to Victoria.*

12. That a Crisis Nurse or equivalent be available 24 hours a day, 7 days a week in all hospitals.

    Coroner's comments: *The jury heard evidence that Hayden had seen a crisis nurse at Campbell River General Hospital in the past however; on the evening of October 18th, the crisis nurse finished her shift at 1930 hours and there was no crisis nurse scheduled until 0930 the following morning. The role of crisis nurse is to evaluate and assess patients who present with addiction and/or mental health issues such as depression or suicidal ideations as well as provide consultation to other colleagues in hospital. The role is available 10 hours a day and the remainder of the time, individuals with a mental health crisis are seen by physicians, nurses and sometimes psychiatrists. The crisis nurse also serves as a link between the hospital and the community professionals such as school counselors.*

13. That training be completed with the College of Registered Nurses of BC to ensure that all staff are aware of the requirements with respect to proper documentation and charting.

    Coroner's comments: *The jury heard evidence from nursing staff at Campbell River General Hospital that several pieces of information were not documented on the hospital chart. For example, during her evidence, a hospital staff member stated that Hayden told her she would hang herself before she left Ledger House. Further evidence revealed that this was neither shared with Ledger House staff nor documented in hospital records. Furthermore, evidence provided by a nurse at Ledger House revealed that during their team meetings where youth are discussed, minutes of the meetings are taken on an infrequent basis or not at all.*

14. That an information guide equivalent to the Orientation to Child and Youth booklet produced by the Families Organized for Recognition and Care Equality (FORCE), be developed and made available to family Health services island wide.

    Coroner's comments: *The jury heard evidence that an orientation guide for families was developed for the South Island area by FORCE and that a similar guide should be created for the North Island area. The existing guide provides information for children, youth and family about existing mental health services, facts about mental health problems, and how and where to access services.*

To: Margot McLaren Moore
Chair
Children's Health Foundation of Vancouver Island / Ledger Program
2390 Arbutus Road
Victoria BC V8N 1V7

15. That upon return to Ledger House from a Pass, the client and parents/guardian be directed to a secure Welcome Room until a debriefing has been completed and the client is deemed safe to be returned to the appropriate Unit. Upon return to the Unit, a risk assessment will then be completed while the parents are afforded the opportunity for a private consultation with staff.

    Coroner's comments: *Then jury heard evidence that upon Hayden's return to Ledger House after her hospitalization on October 18, 2010, there was limited discussion about what took place the night before and no assessment to determine her current mental health status particularly given her physical and emotional condition upon arrival. The jury heard evidence that the parents were not given an opportunity to discuss their views of Hayden over the course of the trip to Victoria and that this was an unusual occurrence as there was typically some formal discussion upon return after a weekend visit.*

16. That in the case of client elopement, the last staff member involved with that client be responsible for directly relaying any and all pertinent information to the 911 dispatch operator.

    Coroner's comments: *The jury heard evidence that the staff person who had direct contact with Hayden prior to her going missing was not the one who contacted 911. The jury heard audio recordings from a staff person who had second hand information about Hayden including what she was wearing and her state of mind.*

17. That all staff employed with Ledger and the Queen Alexandra undergo training in order to ensure familiarity with the grounds both internally and externally.

    Coroner's comments: *The jury heard evidence that the staff were unfamiliar with the grounds of Ledger House and that particularly during searches when dark outside, some knowledge of the area would be helpful in conducting thorough and safe searches.*

18. That immediately upon completion of a risk assessment, the Nurse in Charge (NIC) will be notified and provided with a copy.

    Coroner's comments: *The jury heard evidence that there are different forms of risk assessments available to clinicians in the province of British Columbia and that Queen Alexandra staff all receive training in this area. There is a procedure for completing risk assessments; however, it was unclear if and when the nurse in charge would review these assessments.*

19. That clients and family be made aware that confidentiality may not be maintained if it is deemed that there is a risk to client safety.

    Coroner's comments: *The jury heard evidence from family members that suggested they were unaware of Hayden's risk to harm herself, and they expressed frustration about not understanding what they could be told about Hayden's prognosis in treatment and what they couldn't. The jury heard evidence to suggest that clarifying this point at the beginning of treatment between youth and families would serve the youth and client better.*

20. That regular monitoring and reviews be in place to ensure that the approved recommendations for Ledger House be adhered to.

    Coroner's comments: *The jury heard evidence that the Vancouver Island Health Authority completed a review following Hayden's death which resulted in a number of recommendations all at various stages of implementation.*

To: Inspector Brad Haugli
President
British Columbia Association of Chiefs of Police
C\o: CFSEU Mailstop *#408/409*
14200 Green Timbers Way
Surrey BC V3T 6P3

21. That the BC Association of Chiefs of Police review the report completed by the Saanich Police Department into the review of the police response in relation to the death of Hayden Kozeletski. Further, that recommendations arising from this review be considered for implementation by each detachment across the province to ensure that communication and coordination between police detachments, hospitals and mental health facilities is thorough, consistent, accurate and timely.

    Coroner's comments: *The jury heard evidence that following Hayden's death, a review by the Saanich Police Department found several areas of change that were made, and it was determined that other police forces may benefit from this review in working with hospitals and mental health institutions in various communities across the province*

To: Ms. Lisa Lapointe
Chief Coroner
Office of the Chief Coroner
800 - 4720 Kingsway
Burnaby BC V5H 4N2

22. That the final Verdict and its recommendations be sent to the Minister of Health, Children and Family Development, Education and the Representative for Children and Youth.

    Coroner's comments: *The jury recommended that the final Verdict be sent to these individuals directly as they are key stakeholders in the delivery of mental health services for children and youth in the province of British Columbia.*

23. That the final Verdict at Inquest in this case be shared with all mental health facilities within the province of British Columbia for review and consideration.