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December 19, 2011

The Honourable Ken Champagne
Chief Judge
Provincial Court of Manitoba
5th Floor - 408 York Avenue
Winnipeg, MB R3C 0P9

INQUEST INTO THE DEATH OF ANNA MACIOCHA

Dear Chief Judge Champagne:

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendations into the death of Ms Anna Maciocha. The report dated March 1, 2006 was issued by the Honourable Judge A. Catherine Everett.

Ms Maciocha came to her death in Winnipeg, Manitoba on April 4, 2004 as a result of suicide while an involuntary patient on PY2, a ward at the PsychHealth Unit, Health Sciences Centre.

The Chief Medical Examiner called for an inquest pursuant to subsection 19(3) of *The Fatality Inquiries Act*. The inquest report was released on March 6, 2006.

In this case, Judge Everett made 45 recommendations directed to Manitoba Health. The following are the recommendations and the responses we received:

RECOMMENDATION 1:

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

RECOMMENDATION 2:

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

MANITOBA HEALTH RESPONSE:

The Mental Health Standards committee has developed the parameters of a regional Family Practice Guideline. A regional Family Enhancement Committee was struck to look at ongoing efforts to increase communication and involvement with families and ensure plans are in place at each site for increased communication and bereavement processes.

All sites have developed materials for family orientation and communication based on prototypes developed at HSC that include the need to provide adequate information to families so they can participate in the care of their relative and describes how best they can communicate their concerns to the caregivers.

As well there is a regional Mental Health Advisory Committee made up of consumers and family members who provide input and feedback to the Regional Program on a wide variety of matters.

All sites have a mechanism in place for families to be informed of the complaint process and to utilize the Patient Representative as required.

Family meetings are an expectation at all sites. This requirement has been incorporated into the revised Care Planning Regional Guideline.

RECOMMENDATION 3:

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

MANITOBA HEALTH RESPONSE:

The Mental Health Standards committee developed the parameters of a Family Practice Guideline which includes an emphasis on the importance of involving the patient's family members in the treatment provided to the patient and the importance of inquiring early in the admission process of the patient's wishes regarding disclosure.

Competency and consistency with communication around The Personal Health Information Act (PHIA) and The Mental Health (MH) Act is an ongoing part of orientation and staff development across sites.

Provincial-level Activity

In December, 2005, the “Family Member and Natural Support Participation in Mental Health Service Planning, Implementation and Evaluation” policy was developed by Manitoba Health.

The policy states that mental health planning, implementation and evaluation must reflect a variety of perspectives including those of family members and other natural supports. The purpose of the policy is to direct regional health authorities and the Selkirk Mental Health Centre (SMHC) to develop and implement plans for meaningful family member and natural support participation that will:

offer support to family members and other natural supports;

enhance opportunities to work towards authentic working relationships between consumers, family members, other natural supports, service providers, mental health managers, system planners and policy makers; and

improve the quality of services and consumer satisfaction through effective mental health service planning, implementation and evaluation.

This policy states that “with the informed consent of the individual, family members and other natural supports will be encouraged to play an active role in processes that affect the lives of those living with mental illness”.

RECOMMENDATION 4:

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

MANITOBA HEALTH RESPONSE:

The new Family Orientation Pamphlet prototype developed by HSC was developed for staff to provide to the patient’s noted contact or next of kin upon admission. The revised pamphlet includes a personalized page that identifies the patient’s primary and secondary nurses, the medical student and the resident involved and the attending physician and patient advocate, along with information about the best way to contact these individuals. If the patient has instructed that their family is not to receive information, that information is documented on this page. The provision of this material is documented on the patient’s chart.

RECOMMENDATION 5:

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

MANITOBA HEALTH RESPONSE:

The Mental Health Standards committee developed the parameters of a Family Practice Guideline which includes an emphasis on the importance of involving the patient's family members in the treatment provided to the patient and the importance of inquiring early in the admission process of the patient's wishes regarding disclosure.

RECOMMENDATION 6:

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

MANITOBA HEALTH RESPONSE:

The encouragement of family members to provide information about the patient to the treatment team is included within all of the care planning processes in each site.

RECOMMENDATION 7:

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

MANITOBA HEALTH RESPONSE:

Competency and consistency with communication around PHIA and The Mental Health Act is an ongoing part of orientation and staff development across sites. A consultation process is available for family members who have questions or concerns re: the interpretation of PHIA and The Mental Health Act.

PHIA and communication with families is a standing item on the agenda for all in-patient psychiatrist meetings in the region and medical management has taken a leadership role in discussion and management of this issue.

RECOMMENDATION 8:

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

RECOMMENDATION 9:

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

MANITOBA HEALTH RESPONSE:

The HSC Mental Health program has developed a “Passes – Information for Families/Friends” brochure which sets out basic information about the purpose of passes and encourages the family member to call the unit or bring the individual back early if there are any concerns.

The revised Family Orientation Pamphlet, provided to family members at admission includes a section dealing with passes which set out basic information about the purpose of passes.

RECOMMENDATION 10:

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

MANITOBA HEALTH RESPONSE:

Regional guidelines and protocols have been developed that outline a step wise, timely process re: communication with families after a death occurs. These are existing regional-level WRHA guidelines.

Clear expectations are in place about meeting with families in a timely manner – consistent with WRHA regional policies about disclosure.

RECOMMENDATION 11:

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

MANITOBA HEALTH RESPONSE:

Bereavement processes are in place and activated at HSC and all sites within the WRHA. Regional guidelines and protocols have been developed that outline a step wise, timely process re: communication with families after a death occurs and includes the requirement that the Bereavement Consultant at the Health Sciences Centre should

follow up with the family of the patient within a reasonable period of time following the death. These are regional-level WRHA guidelines.

Each site offers referral to bereavement resources within the city.

Regional Educators have a role in ensuring all staff has ongoing training as required.

RECOMMENDATION 12:

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

MANITOBA HEALTH RESPONSE:

Education about PHIA and The Mental Health Act is an ongoing part of orientation and staff development across sites. PHIA and communication with families is a standing item on the agenda for all in-patient psychiatrist meetings in the region and medical management has taken a leadership role in discussion and management of this issue.

GRANTING OR REVOKING PASSES

RECOMMENDATION 13:

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

MANITOBA HEALTH RESPONSE:

A change in a patient's condition identified by a team member or family member results in revoking the pass until a reassessment is done. This is done by a team member knowledgeable about the patient and subsequently a notification is made to the physician to confirm the assessment. Communication is then made to the patient and/or family and the change is documented in the patient's chart. Passes are not to be re-instated until the patient is re-assessed by a physician.

A clear guideline and process for steps that must be taken once a patient pass is revoked has been developed which includes the time frame for notifying the physician and communication to the patient (and family) regarding the concern.

RECOMMENDATION 14:

After returning from a pass that involves a family member, the unit staff should attempt to obtain information from that family member regarding the pass and the patient's behaviour on the pass

and, based on the clinical importance of the information conveyed by the family, such information should be both charted appropriately and relayed to the appropriate physician.

MANITOBA HEALTH RESPONSE:

A mechanism has been developed to incorporate the family/support person information on the chart or during kardex or treatment planning sessions (not to be confused with the emergency contact person) in order to obtain information from the family member on return from pass. Based on the clinical importance of the information conveyed by the family, such information is charted appropriately and relayed to the appropriate physician.

RECOMMENDATION 15:

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

MANITOBA HEALTH RESPONSE:

Guidelines have been developed to assist staff with decision making re: revoking passes to ensure that the safety of patients is a priority.

All patients (both voluntary and involuntary) will have passes revoked because of suicide risk or safety concerns expressed by family or team member. If concerns are reported by a family member, a team member meets with the patient and does an assessment and documents same.

THE PASS BOOK

RECOMMENDATION 16:

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

MANITOBA HEALTH RESPONSE:

Regional Guidelines have been developed for pass book use to promote consistency in standards of patient care that include the requirement that before an off-unit privilege or pass is granted to a patient for the first time, a member of the treatment team will discuss with the patient his or her responsibility to sign out in the pass book before exercising off-unit privileges and to check in with a nurse before exercising a pass.

The brochure “Information for Patients” regarding passes stipulates that individuals are expected to discuss pass plans with their nurse before leaving on pass.

RECOMMENDATION 17:

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

MANITOBA HEALTH RESPONSE:

Regional Guidelines re passes and pamphlet prototypes for pass information to patients and families have been developed. The new Information Brochure for PY2 has information stating that it is the patient’s responsibility to check in with a nurse prior to exercising passes.

RECOMMENDATION 18:

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

MANITOBA HEALTH RESPONSE:

Regional guidelines have provided a consistent standard re: information around signing out on pass. Pass book sign out is mandatory and is enforced by staff.

RECOMMENDATION 19:

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

- a. the type of pass or off-unit privilege being exercised by the patient;
- b. the date and time the patient leaves the unit;
- c. the patient’s destination; and
- d. the date and time of the patient’s return to the unit.

MANITOBA HEALTH RESPONSE:

The Unit pass book has been standardized to include this information.

RECOMMENDATION 20:

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

MANITOBA HEALTH RESPONSE:

Regional Guidelines for Passes includes pass book use and the requirement that the patient sign the pass book to confirm that he or she has checked in with the nurse prior to signing out.

RECOMMENDATION 21:

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

MANITOBA HEALTH RESPONSE:

Regional Guidelines for Passes were developed to provide direction for assessment and documentation of patients going on pass and returning from pass. The specific information to be included in all unescorted/overnight passes is documented and includes a mandatory assessment by a nurse before a patient leaves the hospital grounds on a pass. For patients returning to the hospital after an unescorted or overnight pass, the patient needs to be assessed to determine if there has been a change in their condition that would require a change in their observation level or passes. Whoever does this assessment is required to document formally that the assessment has been done, and whether the passes or observation level of the patient require change as a result. In addition, the patient must be assessed to ensure that they took their medication and checked to prevent them from bringing anything dangerous back onto the ward.

RECOMMENDATION 22:

The policy regarding AWOL patients needs to be adhered to by staff.

MANITOBA HEALTH RESPONSE:

All sites follow AWOL policies diligently to ensure the priority of patient safety. Regional guidelines have been reviewed and revised as needed regarding time lapses, definitions and protocols well as the guidelines with police regarding communication and processes regarding missing patients.

SUICIDE RISK ASSESSMENT PROCESS AND TRAINING

RECOMMENDATION 23:

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

MANITOBA HEALTH RESPONSE:

A regional one day Suicide Risk Assessment and Intervention Course has been developed by the Regional Educator Group for staff across the sites and programs. The content was reviewed by psychiatry. All staff are required to take the course.

All staff have access to Applied Suicide Intervention Skills Training (ASIST) training as well.

RECOMMENDATION 24:

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

MANITOBA HEALTH RESPONSE:

A refresher course will be developed once all staff are initially trained. Suicide risk assessment is an ongoing component of assessment and planning within the sites.

RECOMMENDATION 25:

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

MANITOBA HEALTH RESPONSE:

Issues related to medical students training have been addressed by the Department of Psychiatry.

RECOMMENDATION 26:

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

MANITOBA HEALTH RESPONSE:

Validated assessment processes have been researched and adopted. A plan for the reassessment of involuntary patients every day has been developed with staff and implemented across all sites.

CHARTING**RECOMMENDATION 27:**

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

MANITOBA HEALTH RESPONSE:

Regional charting guidelines within hospital sites are in existence and have been updated to assist with ensuring that all relevant information is documented in a succinct manner.

The clear expectation to Nurses is that they should prioritize competing demands of the shift changeover to ensure patient charts are read for updated information as close to shift change as possible. Verbal or taped reports are to include pertinent patient care information to provide continuity from shift to shift.

RECOMMENDATION 28:

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

MANITOBA HEALTH RESPONSE:

Review of charting policies and practices across the sites has occurred to ensure that practices are in line with WRHA regional policies. Site Directors and Managers are responsible for ensuring guidelines are being followed.

Regional charting guidelines include the requirement that charts are legible. Audits and follow-ups are part of the process.

Chart legibility is encouraged as peer audit and self-audit to ensure chart notes are legible. Awareness is raised at staff meetings.

Efforts are ongoing regarding implementation of electronic charting. All sites use an electronic Utilization Management Tool on a daily basis to record status with clients regarding readiness for discharge.

RECOMMENDATION 29:

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

MANITOBA HEALTH RESPONSE:

Charting of safety issues involving patient is included in the standard guideline and audit process.

RECOMMENDATION 30:

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

MANITOBA HEALTH RESPONSE:

Primary nurses chart differently from the medical students. Nursing staff change 3 times per day and there is a report process in place for shift change including documentation.

RECOMMENDATION 31:

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

- a. notes must be legible;
- b. notes should be recorded as soon as reasonably practicable;

- c. when it is reasonably practicable to do so, doctors and nurses should review the recent entries on a patient's chart prior to seeing the patient;
- d. typically, notes should include clinically significant observations and facts; and
- e. safety concerns should be emphasized and highlighted.

MANITOBA HEALTH RESPONSE:

Each site has reviewed their own practices on each of these and put in place guidelines to allow staff to comply with this recommendation including legible charting, timely documentation, the requirement that doctor and nurse are to review the most recent entries prior to seeing the patient, clinically significant observations and facts are documented in the chart, safety concerns highlighted and emphasized.

RESOURCES

RECOMMENDATION 32:

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

RECOMMENDATION 33:

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

MANITOBA HEALTH RESPONSE:

Enhanced communication processes between physicians and the teams have been addressed to ensure improved continuity related to coverage and vacation. Appropriate communication (hand-over) from one attending to another will accompany any planned absence from the facility (vacation, conference, etc.). Communication is to include an "off-service" note and a clear documentation of transfer of care from Physician "A" to Physician "B".

In some sites the ratio of "patients to attending physician" has been reduced.

RECOMMENDATION 34:

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

MANITOBA HEALTH RESPONSE:

Discharge practices have been altered to ensure patients and passes are distributed across the days of the week and not on week-ends only.

ACCESS TO PHYSICIANS AND PATIENT REQUESTS FOR TREATMENT**RECOMMENDATION 35:**

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

MANITOBA HEALTH RESPONSE:

The Mental Health Standards Committee did not develop a guideline regarding patient access. This is a part of standard care planning principles and this expectation has been communicated to all staff. Early in the treatment plan the attending physician/resident does document the frequency of patient meetings with attending as a component of the treatment plan. The frequency of reassessment is dependent on the specific case and treatment planning is a team approach and documented in the record as part of the care plan. The frequency is to be routinely reviewed, revised as needed, and communicated to the health care team.

RECOMMENDATION 36:

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

RECOMMENDATION 37:

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

RECOMMENDATION 38:

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

MANITOBA HEALTH RESPONSE:

The Mental Health Standards Committee developed guideline parameters that include that a patient request for consultation with an attending physician is documented and the

response recorded and that the attending physician/resident will document the frequency of patient meetings with attending as a component of the treatment plan. Frequency as a component of the treatment plan is to be routinely reviewed revised and communicated to the health care team.

The treatment plan is to be reviewed revised and communicated to the health care team and patient on an ongoing basis.

RECOMMENDATION 39:

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

MANITOBA HEALTH RESPONSE:

Appropriate communication (handover) from one attending to another will accompany any planned absence from the facility (vacation, conference, etc.). Communication is to include an “off-service” note and a clear documentation of transfer of care from Physician “A” to Physician “B”.

CRITICAL OCCURRENCE PROCEDURES

RECOMMENDATION 40:

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

MANITOBA HEALTH RESPONSE:

All cases in which a patient receiving psychiatric care (from a WRHA facility or program) completes suicide shall be reviewed, with a view to learning about any factors that may have contributed to the event. Although this is the present practice at sites, the WRHA Program has promoted discussion and has adopted a systematic review process related to suicide that is consistent across sites and includes the requirement that all staff involved in the care make notes of all their involvement in the time period leading up to the patient’s death.

RECOMMENDATION 41:

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

RECOMMENDATION 42:

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

RECOMMENDATION 43:

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

MANITOBA HEALTH RESPONSE:

The Mental Health program of the WRHA has worked with the regional WRHA Patient Safety Team and the implementation group for The Regional Health Authorities Amendment Act concerning details of safety investigation methodology. Individuals conducting the review will include an experienced psychiatrist. No staff directly involved with the care of the patient will be part of the review team.

Processes will be consistent with the regional, facility, and program processes for all patient safety investigations, as well as being fully aligned with legislation.

RECOMMENDATION 44:

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

- a. at least two interviewers;
- b. interviews of all individuals who were involved with the patient's case;
- c. preparation of notes with respect to the information gathered during the interviews;
- d. a review of the patient's medical records; and
- e. preparation of a chronology and report that will set out the possible causes of the suicide and, if appropriate, recommendations to prevent a similar occurrence in the future, and an action plan with timelines.

The report should then be used as a learning tool.

RECOMMENDATION 45:

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

MANITOBA HEALTH RESPONSE:

The components for the review of suicides in a facility are covered by the new processes in place within the WRHA related to the investigation of Critical Incidents. All of the elements in these recommendations are covered by the processes in place.

As we have now received and reported upon the response from Manitoba Health to which recommendations were made, our file on this matter will now be closed.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

cc: Mr. Milton Sussman
Deputy Minister of Health

Dr. Thambirajah Balachandra
Chief Medical Examiner

Ms Arlene Wilgosh
CEO, Winnipeg Regional Health Authority