

Manitoba Ombudsman

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August 31, 2017

The Honourable Margaret Wiebe
Chief Judge
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

Inquest into the death of Craig Kucher
Department: Manitoba Health, Seniors and Active Living
Our file: 2016-0135

Dear Chief Judge Wiebe:

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a Manitoba government 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 Mr. Craig Kucher. The inquest report, dated April 7, 2016, was released by the Honourable Judge Donovan Dvorak on April 13, 2016.

Mr. Kucher, aged 27 years, died on June 18, 2012, in Brandon, Manitoba, from injuries sustained from a train accident. At the time of his death, Mr. Kucher was on a two day leave of absence as an involuntary patient of the Centre for Adult Psychiatry, Brandon.

In his inquest report, the Honourable Judge Dvorak made three recommendations which involve Manitoba Health, Seniors and Active Living as follows:

Recommendation One:

Ensure that clear protocols are in place at all mental health facilities that would direct the authorizing physician to ensure that the person or persons taking responsibility for a patient to be released on a temporary leave understand what is expected of them by way of supervision of the patient, any potential signs of illness relapse, medication dosage and administration, and any potential contra-indications between the prescribed medications and illicit drugs and/or alcohol.

Recommendation Two:

Ensure that clear protocols are in place at all mental health facilities that would direct the authorizing physician to ensure that the patient to be released on a temporary leave is aware of the physician's expectations as regards the patient's cooperation with treatment and supervision, medication dosage and administration, the possible impact of the use of illicit drugs and/or alcohol and the circumstances which would necessitate their return to the mental health facility prior to the end of the leave.

Recommendation Three:

Written copies of that information should also be provided to the patient and the person or persons taking the patient into their care.

On December 6, 2016, we received the following response regarding the inquest recommendations from Manitoba Health, Seniors and Active Living.

Following receipt of the letter dated August 8, 2016 from your office, the Department conducted a scan of implementation of these three recommendations in mental health facilities identified in the Facilities Designation Regulation under The Mental Health Act. In doing so the Department made contact with all Regional Health Authorities (RHAs) that operate psychiatric facilities/units. Two psychiatric centres not operated by RHAs were also contacted (Selkirk Mental Health Centre and Eden Mental Health Centre) and are included in the review.

Implementation of the recommendations varies somewhat across RHAs and the two psychiatric facilities; however, they are presently taking the necessary actions as required, to attain compliance.

Follow up inquiries with the department were made in April and June 2017. On June 15, 2017, we received additional information from Manitoba Health, Seniors and Active Living advising that the recommendations have been implemented and that the scan as described above on December 5, 2016, included the following:

This included three RHAs: Winnipeg Regional Health Authority (WRHA), Prairie Mountain Health Authority (PMHA) and Northern Health Region (NHR). The Department also contacted three psychiatric facilities: Selkirk Mental Health Centre (SMHC), Manitoba Adolescent Treatment Centre (MATC) and Eden Mental Health Centre (Eden).

All jurisdictions reviewed and, where required, updated their protocols to align with the recommendations. It is the view of the Department that the approaches used in all jurisdictions are consistent with the three recommendations of the Kucher Inquest regarding temporary leaves. The protocols on which leaves are founded are based on evidence informed practices.

There are a few noteworthy exceptions to jurisdictions' implementation of these recommendations, required by the clinical circumstances of individual cases, and founded upon expert clinical assessments and informed judgment.

The attending physician does not personally implement the recommendations in all cases. On occasion, orders for temporary leaves are written by other clinical team members depending upon the clinical location (e.g. non-hospital based facilities such as crisis stabilization units). Other clinical team members may include nurse practitioners, physician assistants, nurses and crisis unit practitioners.

When patients go on multiple temporary leaves over a brief period of time (i.e. within a 24 hour period), discussion with the patient/supervising individual about expectations prior to each leave may not always be clinically necessary is done at the discretion of the clinicians based upon their assessment. A number of factors are carefully considered when making these decisions, including whether the patient had a prior positive or negative leave experience, response to treatment, changes in clinical status, risk for suicide, medical/physical risk factors, risk of elopement, family/supports, and risk of use of alcohol/drugs.

Information about the possible impacts of the use of illicit drugs and/or alcohol on the patient's prescribed medications is included on the leave/pass information provided to patients/supervising individuals by all jurisdictions. In exceptional situations, discretion is used regarding the appropriateness of discussing this with the patient/supervising individual. Situations where this may not be appropriate for discussion, include the following:

- *With young children (≤ 10 years); and/or*
- *Children, adolescents or adults with neurocognitive or developmental disabilities whose history indicates an absence of use of illicit drugs and/or alcohol, and/or whose cognitive development precludes their comprehension of such matters.*

Given that the department has provided its full response to the judge's recommendations, we will be concluding our monitoring of the implementation of the Craig Kucher inquest recommendations.

Please note, an electronic copy of this report will be posted on the Manitoba Ombudsman website: www.ombudsman.mb.ca.

Yours truly,



Charlene Paquin
Manitoba Ombudsman

cc: Karen Herd, Deputy Minister of Health, Seniors and Active Living