

Manitoba Ombudsman

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June 14, 2018

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

**RE: Inquest into the Death of Michael Winsor
Our File No. 2017-0239**

Dear Chief Judge Wiebe:

As you are aware, it is the practice of our 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 our office concerning the recommendations made by the Honourable Judge Pollack in his report regarding the Inquest into the Death of Michael Winsor, issued May 16, 2017.

BACKGROUND

Michael Winsor died on September 10, 2013 at the Health Sciences Centre (PsychHealth Unit PY3 South) in Winnipeg, Manitoba. Mr. Winsor was an involuntary patient at the PsychHealth Unit, having been admitted for an observation period pursuant to The Mental Health Act, C.C.S.M. c. M110. He caused his own death by strangulation by using a wet towel as a ligature to partially suspend himself from a towel bar.

RESPONSE TO INQUEST RECOMMENDATIONS

In the inquest report, the judge made three recommendations. All recommendations involved Manitoba Health, Seniors and Active Living (Manitoba Health). Manitoba Justice was also involved in the implementation of one of the recommendations.

We made inquiries with Manitoba Justice and Manitoba Health on September 1, 2017 regarding what steps had been taken, if any, to implement the recommendations in this matter. The response of Manitoba Justice was received by our office on September 28, 2017. An interim

report from Manitoba Health was received on November 23, 2017, with the final response following on May 29, 2018.

Manitoba Health advised our office that the implementation of the recommendations has been done in collaboration with the relevant psychiatric facilities, namely:

- Eden Mental Health Centre
- Manitoba Adolescent Treatment Centre
- Selkirk Mental Health Centre
- Regional Health Authorities (Northern Health Region, Prairie Mountain Health Region, Southern Health-Santé Sud, Winnipeg Regional Health Authority)

The responses received from both departments are set out below.

Recommendation #1

It is recommended that all Manitoba health authorities carry out the necessary renovations to remove ligature points and other protrusions that enable self-harm in facilities where mental health patients require privacy.

With respect to Recommendation #1, Manitoba Health advised our office that it convened a meeting of the relevant facilities and regional health authority representatives on October 3, 2017 to review industry standards and best practices associated with ligature points and protrusions.

In its response of May 29, 2018, Manitoba Health has advised it is taking a phased approach in implementing this recommendation. It stated that immediate actions have been taken or are planned to renovate or remediate the highest-risk areas in inpatient psychiatric facilities in a timely fashion, where all of the following conditions are present:

- High-risk ligature points and protrusions exist,
- Patients may be a high-risk for suicide, and
- Patients require privacy.

Manitoba Health explained in its responses that inpatient psychiatric facilities and units are located in Prairie Mountain Health Region, Northern Health Region, Winnipeg Regional Health Authority, Eden Mental Health Centre, Manitoba Adolescent Treatment Centre, and Selkirk Mental Health Centre. Manitoba Health further advised that plans are in place or under development to address medium and low-risk inpatient areas where mental health patients may be admitted.

Manitoba Health has stated that it will be responsible for following up with the regional health authorities and facilities with respect to the implementation of Recommendation #1.

Recommendation #2

It is recommended that Manitoba legislative and law reform authorities examine The Mental Health Act and The Police Services Act and take all necessary steps, to introduce law amendments if necessary, to permit a police officer who has brought an involuntary mental health patient to a health care facility to transfer custody of the patient to a peace officer employed by that health care facility.

Manitoba Justice and Manitoba Health provided the same response to this recommendation as its implementation involves both departments. They have advised that Bill 3, The Mental Health Amendment Act, received Royal Assent on June 30, 2016. As per Manitoba Justice's response of November 21, 2017 and Manitoba Health's response of May 29, 2018, once proclaimed, this Act will enable peace officers to transfer custody of individuals detained under The Mental Health Act to qualified persons at health care facilities. "Qualified persons" are individuals who have been appointed to a specified position or have received required training as regulated under the Act. Manitoba Justice advised that this provides the flexibility to engage and/or train a range of persons who could perform this duty in place of police officers.

On November 21, 2017, Manitoba Health advised our office that, together with Manitoba Justice, it was working with an advisory committee of security, police and regional health authority personnel to develop the regulations required to implement the amendments. Manitoba Health advised that an "incremental plan" for implementation would commence in 2018, with the intention of having qualified persons in place in select facilities, with sites to be selected based on availability of individuals who could be trained as "qualified persons" and the frequency of police escorts of patients to the facility for involuntary assessment.

Manitoba Health has advised that as of May 2018, regional health authorities and facilities are in the process of implementation planning pertaining to the legislative changes and are doing so under the guidance and oversight of Manitoba Health and Manitoba Justice. We note that to date, The Mental Health Amendment Act has not yet been proclaimed.

Recommendation #3

When a death occurs and it is clear that an inquest will take place, either because of the mandatory requirements of The Fatality Inquiries Act or the obvious need for an inquest because of the circumstances of the death, it is recommended that all Manitoba health authorities involved make their staff members aware that an inquest will be held at some time in the future and that it is desirable for them to make and to keep an account of their connection with the death to enable them to provide testimony.

Manitoba Health has advised that on October 3, 2017, it convened a meeting of the relevant facilities and regional health authorities and confirmed that the following practices are followed in relation to documentation and its use in an inquest:

- Documentation in the official patient record is the primary source of information used for inquest investigations. It is a professional standard that all service providers in mental health facilities and/or psychiatric inpatient units will fully, appropriately and in a timely fashion document patient observations, assessments and actions taken in the official patient record.
- Staff documentation in other non-official formats (e.g. personal notes) could contravene The Personal Health Information Act or The Mental Health Act (as applicable) in relation to the collection, use, disclosure and security of personal health information. Such a practice could also contravene professional, regional and facility standards for documentation. Therefore, staff are directed to record all necessary information in the patient record.

Manitoba Health advised us that at least one regional health authority has a process for enabling employees and former employees to view their entries into the health record for legal proceedings in which the regional health authority is a party, including inquests. Manitoba Health also explained that for inquests, any relevant record is usually part of the productions disseminated to legal counsel under a production order. As such, the regional health authority's legal counsel are able to show employees and former employees their entries in advance. Employees and former employees also have access to the complete chart when in court.

In its final response of May 29, 2018, Manitoba Health advised that all regional health authorities, Eden Mental Health Centre, Manitoba Adolescent Treatment Centre and Selkirk Mental Health Centre have undertaken assessments of their existing policies and practices related to Recommendation #3. It states that all of these bodies have standards or policies which have either been implemented or are presently under development in order to ensure that the intent and spirit of Recommendation #3 are addressed.

CONCLUSION

Given that each of the recommendations in this matter either have been or are in the process of being implemented by Manitoba Health and/or Manitoba Justice, our office is concluding our monitoring of this matter at this time.

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

Yours truly,

A handwritten signature in black ink, appearing to be 'CP' with a long horizontal stroke extending to the right.

Charlene Paquin
Manitoba Ombudsman

cc: Karen Herd, Deputy Minister of Manitoba Health, Seniors and Active Living
Dave Wright, Deputy Minister of Manitoba Justice
John Younes, A/Chief Medical Examiner, Manitoba Justice