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December 24, 2010

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

Dear Chief Judge Champagne:

Re: Inquest into the Death of Peter Stevenson

I am writing to advise of the results of the inquiries made by my office concerning the inquest report recommendations dated October 25, 2006, issued by the Honourable Judge Roger J. C. Gregoire into the death of Peter Stevenson.

On September 2, 2004, Peter Stevenson, age 30 years, died as a result of sudden cardiac arrest consistent with agitated delirium at The Pas Health Complex.

The Chief Medical Examiner called an inquest pursuant to clause 19(3)(a) of *The Fatality Inquiries Act*. The inquest report was released on October 30, 2006.

As you are aware, it is the practice of my office to follow up on inquest recommendations if they involve a provincial department, agency or municipality. In this case my office made inquiries with Manitoba Health and Healthy Living, Justice, Family Services and Consumer Affairs and the NOR-MAN Regional Health Authority.

The following are the recommendations followed by the response my office received from the department(s):

RECOMMENDATION ONE

I recommend that there be an awareness campaign and training for all of those who work in psychiatric wards, hospitals, emergency rooms, security and law enforcement and for all those who may transport mentally ill patients, as to the signs, symptoms and potential outcome of excited delirium.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

Manitoba Health and Healthy Living has convened a committee of representatives from the mental health and addictions policy branch, regional support staff, a mental health educator and the mental health manager from the NOR-MAN Regional Health Authority to assess current training and ensure that the signs, symptoms and potential outcome of excited delirium, specifically awareness and training of the possible risks to the life of an individual who is restrained in the prone position for any length of time is included in future training for all regions. Some regions have already incorporated training about excited delirium into their ongoing internal “Code White” training.

Further, this group will have responsibility for addressing Recommendation #3 pertaining to prevention in crisis intervention with individuals at risk of excited delirium: that all possible efforts are made and care taken to avoid that person from entering into this excited delirium state recognizing that once it occurs it can lead to fatal consequences.

Staff has discussed the training requirements of “excited delirium” with the Crisis Prevention Institute (CPI). CPI trains a number of Manitoba health professionals in the “Non-Violent Crisis Intervention Training Program”: the safe management of disruptive and assaultive behavior. The institute has committed to enhance resources on their website related to the risk of using restraints with the reminder that it always should be a last resort, including a link to an article on the subject. The Institute did not feel it was necessary to change their training materials.

The Provincial Medical Director, Land Ambulance Program, Province of Manitoba, has reviewed the issue of agitated delirium and believes that current Emergency Medical Services (EMS) protocols are sufficient to provide for the needs of a patient with agitated delirium, as the treatment is supportive care with attention to patient and staff safety, and the EMS training adequately addresses these principles.

Agitated Delirium was added to the agenda for discussion at the Manitoba Emergency Services Medical Advisory Committee (MESMAC) meeting in April 2007 to determine what (if any) specific training needs to be provided to EMS staff to address this issue. Following is a synopsis from minutes from the discussion at that meeting:

“Excited delirium is a poorly understood phenomenon whereby a person who has altered mental status due to an organic medical condition (i.e. delirium) becomes extremely agitated, and may experience sudden (and possibly catastrophic) deterioration.

Patients in this state may suffer from cardiac arrest and resuscitation is not always successful. Often in these cases post mortem examination fails to find a cause of death.

Excited delirium may be caused by a number of medical factors, including (but not limited to) prescription drug side-effects, substance intoxication, infections, and hypoglycemia.

Current Manitoba EMS treatment guidelines, protocols and training include the management of patients with an altered mental status.

Included are:

- 1. Issues of patient and staff safety (including restraint, sedation and the need for law enforcement backup).*
- 2. Ongoing monitoring of a patient's medical status and stability (i.e. vital signs, blood sugar and level of consciousness), and the recognition of a deteriorating patient.*
- 3. Management of acute medical conditions, including the management of unstable, deteriorating patients (i.e. supportive care).*

Therefore, it was the conclusion of the committee that at the present time, EMS personnel are adequately trained to deal with patients who may experience excited delirium."

On December 14, 2010, Manitoba Health further advised:

We have now reconfirmed with all regional health authorities the requirements related to the above recommendation for those who work in emergency rooms. We can inform you that regional health authorities have incorporated information regarding excited delirium into existing educational programs such as non-violent crisis intervention programs and Code White training, or are in the process of ensuring its inclusion in upcoming and ongoing training and education.

MANITOBA JUSTICE RESPONSE

Sheriff's officers:

The Provincial Training Coordinator for Sheriff Services advises that training will take place utilizing the following training material and timelines:

- 1. Manitoba Corrections has provided Sheriff Services with a PowerPoint presentation and handouts dealing with excited delirium training currently provided to correctional officers across the province. The presentation and handouts will be adjusted so that it accurately meets the needs of Sheriff Services.*

2. *The trainers will establish timelines for the training sessions required. The entire presentation should take between 30 to 45 minutes depending on the questions or issues raised by the officers. It will take several sessions based on staff considerations to train all the officers in each office.*
3. *All new officers will receive this training as part of their recruit training.*
4. *Based on the level of training being provided, annual recertification will not be required. The Provincial trainer will continue to monitor the issue of excited delirium and make changes to the presentation and handouts as new information becomes available.*
5. *When new information is received, staff will be advised of the changes and depending on the magnitude of the changes may be provided with a new training session.*

On February 10, 2010, my office was advised that all Sheriff's officers completed this training in 2009.

Correctional officers:

The Corrections Division of Manitoba Justice indicates that this recommendation is not a concern as training on excited delirium and positional asphyxiation has been occurring since 2003. Specifically, members of the Correctional Emergency Response Unit (CERU), Female Cell Extraction Team (FCET), Incident Response Team (IRT), TASER operator course and Oleoresin Capsicum ("OC Spray") course participants receive training in a 15-minute presentation on the risk indicators and danger signs on the potential of Sudden In-Custody Death occurrences. If risk indicators are exhibited, correctional officers are expected to monitor respiration and pulse until the person is examined by medical department personnel, but if no medical personnel are available, the condition is treated as a medical emergency and the person is transported to the closest emergency hospital centre.

Training on excited delirium and positional asphyxiation is not currently provided to all correctional officers in Manitoba, but Corrections Division believes that this does not pose a difficulty because on any shift there are always three or more correctional officers who are members of the above noted groups that have received the specialized training. Further, if a situation arises where the IRT or CERU units are required to assist, each member on that specialized team has the specialized training to handle situations regarding excited delirium, should they arise.

Police officers:

Royal Canadian Mounted Police (RCMP)

RCMP indicate that this recommendation is not a concern as a policy setting out a detailed explanation of the signs and symptoms of excited delirium, instructions

to ensure that members seek immediate medical assistance for anyone exhibiting symptoms, and instructions to avoid restraining a suspect in the prone position due to the risks associated with positional asphyxiation was distributed by Division Headquarters to all unit commanders to share with their members. Training Services has also incorporated an excited delirium lesson plan into the public and policy safety course which is offered to general duty officers, as well as on the initial training and subsequent re-certification courses for users of the Taser.

Municipal officers (including Winnipeg Police Service, Brandon Police Service and smaller police forces)

These forces indicate that this recommendation is not a concern as officers receive training during the “use of force” portion of their training, to identify and deal with persons who may be experiencing excited delirium, and policy guidelines have been adopted accordingly. Hog tying prisoners in the prone position is prohibited.

RECOMMENDATION TWO

Specifically awareness and training for the above persons of the possible risks to the life of an individual who is restrained in the prone position for any length of time especially for an individual who may be at higher risk of dying from excited delirium, i.e. psychiatric patients, especially if on anti psychotic drugs and known users of cocaine or crystal meth.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

Currently the Non-Violent Crisis Intervention Training Program does not include specific reference to the constellation of symptoms known as “excited delirium”, although it does include a section on the dangers of restraints and specifically refers to restraint-related positional asphyxia. The Instructors manual has an entire section - (Unit 8) Signs of distress. This is the section used by the Instructors to educate on understanding the risks of restraint.

MANITOBA JUSTICE RESPONSE

Sheriff’s officers:

The Sheriff Services does not see this as a problem in Manitoba. The Sheriff Services does not sanction cuffing or restraint in the prone position for an extended time. That practice is only to be used when absolutely necessary in order to apply restraints, after which the person is placed in an upright position. Secured prisoners are restrained in the upright position throughout an entire transport or in lockup. The policy of upright restraint reduces the element of constriction or positional asphyxiation which is a cause in the acceleration of excited delirium. If there are no security issues, restraints are removed while in lockup.

In addition, policy dictates a 15-minute check on all prisoners. In situations involving aggressive prisoners in lockup, restraints will be applied and the subject will be moved to a video cell wherein continuous monitoring will be conducted. Three variants of upper body restraints are utilized by the Sheriff Services, but when excited delirium is a concern, officers can utilize the least restrictive position to increase a sense of comfort and avoid an increase in apprehension.

Correctional officers:

Corrections does not believe this a concern in Manitoba as all correctional officers are taught through Central Basic Training and the Institutional Security Refresher (ISR) course and other programs that “hog tying” or positional restraint of persons is strictly prohibited and that if a higher level of restraint equipment is required, beyond conventional handcuffs and leg irons, the Emergency Restraint Chair (ERC) is to be used. ERC is used by the majority of the facilities within Manitoba and all members must be trained and familiar with its use, including viewing the instructional information video.

Police officers:

RCMP

RCMP does not see this as a problem in Manitoba. Due to the risk of positional asphyxia when “hog tying” a suspect, this practice is no longer encouraged. Instead, RCMP stopped using the TARP restraint system (total appendage restraint procedure) and switched to the RIPP hobble system which allows the prisoner to sit up rather than be in a prone position when restrained. Other RCMP approved restraints include: restraining belt and jacket, emergency restraint chair or prostraint chair, handcuffs, leg irons, tie plastic (flex-cuff), cord cuff and Transport hood (head covering to prevent the suspect from spitting, sneezing or coughing at officers, that is not to be applied on any person who is unconscious, vomiting, bleeding from the mouth and nose, in respiratory distress or in a obvious need of medical assistance, and the prisoner is to be constantly monitored).

Municipal officers:

This is not a concern as “hog tying” prisoners in the prone position is no longer permitted.

RECOMMENDATION THREE

The establishment of a protocol in order that information that is known by one care giving governmental agency can be shared with other such departments or agencies where it is reasonable to believe that the sharing of the information could be in the best interests of the client/patient. In particular in this type of situation that the psychiatric ward, community mental health and the supported living program not only share their information but use their resources in an integrated fashion in order to better serve the needs of the client/patient. I note that Mr. Stevenson also had some involvement in the justice system as well and as such this sharing and

integration could extend as well to services such as probation and/or corrections. The hope is that by better serving the individual, the less stressors he may be faced with and therefore it may be less likely that his schizophrenia would reach an acute phase and that he would require hospitalization and find himself in the situation that Mr. Stevenson was in.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

Provincial protocols for a cross departmental approach to service coordination for high risk/high needs adults was developed in October 2005 in Manitoba. It was implemented across the participating departments of Family Services and Housing, Justice, and Health shortly thereafter with province wide cross-departmental staff training.

The protocols were the result of recommendations made by a Provincial Court Judge who convened an inquest into the death of a young girl in Manitoba. They were developed to apply to work with adults with special needs (i.e. who have a mental disorder or mental disability) who have a history of violent behavior, and who pose a risk of serious danger to the public.

The basic criteria are:

- 1. Limited or impaired self-control due to a mental disorder or mental disability. While a definitive assessment is not currently required, the individual may be suspected as having a mental disorder or mental disability or both. A more definitive assessment may be required as part of the development of an intervention or service plan; and*
- 2. Assessed to be a serious threat or danger to others or themselves, or posing a risk of serious danger or serious threat to public safety. These individuals are referred where there is a high probability that behaviors or re-offending could pose a serious threat to themselves or to public safety. These individuals may be easily influenced by others, have addiction issues, or may be non-compliant with treatment, medical care and medications, increasing their chances of becoming involved in dangerous behaviors; and*
- 3. History of violent behavior which is dangerous to the public. Examples of offences which are considered dangerous are sexual assaults, physical assaults, arson etc. These behaviors are generally chronic and pervasive. It is not a requirement that these individuals have been charged and found guilty of offences, but should have a known and documented history of violent behavior or potentially violent behavior, which places them or others in danger.*

With respect to Mr. Stevenson, it was clear that he would have met the first two criteria: 1) he had a diagnosis of Schizophrenia as well as limitations cognitively due to FASD and 2) his behavior could have been assessed as posing a risk to his

own safety. Although he did have exposure to the Justice system, he likely would not have met the third criteria (i.e. a history of chronic and pervasive violent behavior which is dangerous to the public).

A request has been made to the Provincial Special Needs Committee to review this recommendation at the next meeting: to evaluate if the Protocols could have been used in the case of Mr. Stevenson or if they need to be changed in any way to accommodate individuals with his needs. If deemed necessary, staff will coordinate with Family Services and Housing and will consider the provision of a refresher session on the protocols in NOR-MAN RHA with participants to include collateral agencies.

Manitoba Health and Healthy Living later advised that:

The Committee agreed that the Protocols could have been used in this circumstance, but that it would not have been mandatory, as Mr. Stevenson did not fit the criteria related to a risk of serious danger to the public.

This recommendation was provided to the Provincial Co-occurring Disorders Leadership Team at its meeting in September [2007] to discuss the possibility of developing a Guideline for the sharing of information between service providers for individuals with co-occurring mental health and substance use disorders. Such a protocol is in place in Winnipeg and it might be of use in other parts of the province as well. The Co-occurring Disorders Leadership Team agreed to develop a provincial guideline.

Manitoba Health and Healthy Living has since provided my office with a finalized copy of the Guideline in keeping with the “best practice”, a Comprehensive, Continuous, and Integrated System of Care Model for individuals with co-occurring mental health and substance use disorders. It is a fundamental principle of integrated care that everyone works on the same treatment plan: “One Team with One Plan for One Person”.

FAMILY SERVICES AND CONSUMER AFFAIRS RESPONSE

Staff of the Department’s Service Delivery Support Branch are reviewing the status of the High Risk Protocol for Complex Needs Clients with staff of the Northern Region to determine if further orientation, training and/or implementation sessions of this protocol are required. Although staff are familiar with this protocol, consideration is being given for a refresher session at either Flin Flon or The Pas, with participants to include collateral agencies, organizations and staff of the Regional Health Authority.

Family Services and Consumer Affairs later advised that:

As noted in my letter to you dated March 30, 2007 departmental staff were reviewing the High Risk Protocol for Complex Needs Clients with staff of the

Northern Region. Subsequently, senior staff of the Department's Community Service Delivery Division provided refresher training on the protocol to new Supported Living Program staff, Mental Health and Employment and Income Assistance workers, and members of the RCMP in Flin Flon on June 19, 2007.

MANITOBA JUSTICE RESPONSE

Correctional officers:

Corrections note that concerns about this have not been identified with the current information sharing system. Corrections Division utilizes COMS, an internal system that contains current and running logs of information respecting provincial offenders. It is shared by probation and correctional services and entries are current. Any medical concerns identified during involvement with an offender, or received from other sources, for example, information obtained during preparation of a pre-sentence report, are noted.

Sheriff's officers:

Based on The Freedom of Information and Protection of Privacy Act, the amount of medical information provided to Sheriff Services and correctional officers is limited. The Department is continuing to explore this issue to ensure that relevant information is provided to those who are about to assume responsibility for an individual.

Police officers:

RCMP

RCMP indicate that concerns have not been identified with the current internal information sharing system. Once a suspect has been dealt with by police, all pertinent information about the prisoner can be logged into the computer system to be accessed for future reference.

Municipal officers:

This is not a concern as the majority of municipal forces have internal information systems, in which pertinent medical information that becomes known to police, can be recorded and accessed by officers, as needed. There are some small departments that do not have internal information systems per se, although officers would, through personal experience have knowledge regarding a suspect's medical status. For serious incidents, it is likely that in those areas, RCMP would be the responding agency.

Our office made further inquiries with Family Services and Consumer Affairs, Manitoba Health and Manitoba Justice to clarify if the above noted action fully addressed the spirit and intent of the Recommendation. We received the following response from the Deputy Ministers of the above noted departments:

In 2005, the protocols and consent form for a cross departmental approach between Health, FSCA, Justice, Regional Health Authorities (RHAs) and other

agencies for the service coordination of high risk/high needs adults were finalized and implemented (Cross Departmental Protocols for High Risk/High Needs Adults).

The purpose of the protocols is to provide Health, FSCA, Justice, RHAs and other agencies with a process to undertake coordination of services for the target group noting that most offenders have multiple service needs. An interdisciplinary approach, in which service personnel collaborate and cooperate allows for provision of the best services. After assessment of needs, eligible clients are referred to existing programs such as the Supported Living, Community Mental Health or Justice programs. If ineligible for these programs, clients may be referred to the Provincial Special Needs Program.

In terms of current use of these protocols:

- *Regional Health Authorities' Mental Health Program Managers reported that the protocols were being used and that they have had success meeting the needs of their clients through the use of the protocols.*
- *Provincial Corrections staff are using the protocols to plan for youth transitioning to adults/adulthood as well as adults leaving the correctional system.*
- *Through the use of the protocols, FSCA staff have referred clients with multiple service needs to the Provincial Special Needs Program (PSNP). If clients are not eligible for PSNP funds or existing FSCA programs, staff have capitalized on their multi service expertise to effectively minimize the risk to the client*

The Province of Manitoba has been or is in the process of developing services for complex multi-needs vulnerable individuals. Current new programs that use cross departmental planning for complex multi-needs vulnerable individuals that have been implemented or are in the process of being implemented include:

Spectrum Connections FASD Services

- *Homeless Strategy with an emphasis on mental health housing*
 - *Housing with Services*
 - *Portable Housing Benefit*
 - *Community Wellness Initiative. [Winnipeg Regional Health Authority (WRHA) and Tenant Services and Asset Management in specific Manitoba Housing sites]*
 - *An increase in emergency shelter beds*
 - *Permanently house long-term shelter users with supports, and*
 - *Funding of seven outreach mentors to work with vulnerable people living in the community. The outreach mentors will work out of the Main Street Project, Salvation Army, RAY, Spence Neighbourhood*

Association, CMHA Westman, CMHA Thompson and The Pas Friendship Centre

- *Winnipeg Co-occurring Disorders Initiative (support to Justice by the WRHA and the Addictions Foundation of Manitoba)*

RECOMMENDATION FOUR

That to the fullest extent possible when dealing with individuals such as Mr. Stevenson that all possible efforts be made and care taken to avoid that person from entering into this excited delirium state recognizing that once it occurs it can lead to fatal consequences.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

See above response to Recommendation #1. Training in Non-violent Crisis Intervention includes specific training on de-escalation of emotional situations.

FAMILY SERVICES AND CONSUMER AFFAIRS RESPONSE

The Department defers this recommendation to Manitoba Health, the jurisdiction under which issues of health matters fall.

MANITOBA JUSTICE RESPONSE

Correctional officers:

Correctional officers are made aware of the risk indicators and behavioral signs which may be related to excited delirium, and the need to be vigilant when dealing with potential use of force on unpredictable offenders and if any of the risk indicators are present, medical assistance should be undertaken (i.e. monitor respiration and pulse). Prone position restraints (“hog tying”) is strictly prohibited as it can exacerbate the situation, instead, the ERC is to be used.

Sheriff’s officers:

Sheriff Services is currently undertaking the steps outlined under Recommendation 1 to train officers on the recognition of excited delirium and the first aid steps that should be taken should an individual in their custody encounter this medical condition. Sheriff Officers are also trained in CPR and First Aid Level C.

The policy of using upright restraint reduces the possibility of constriction or asphyxiation, while preventing an escalation of the person’s emotional/physical agitation. Continuous monitoring also assists, including offender’s movement in video monitored vans.

Additionally, we were informed that Manitoba Sheriff's officers receive Non-violent Crisis Intervention Training. This type of training is explained in the responses provided by Manitoba Health and Healthy Living.

Manitoba Justice also advised that:

Police officers:

RCMP

This recommendation is not a concern as RCMP officers have been trained to identify symptoms associated with excited delirium and respond appropriately, for example, by seeking immediate medical attention; and policies have been adopted in this regard.

Municipal officers:

This recommendation is also not a concern as officers have been trained to recognize excited delirium as a potential outcome and have incorporated policy guidelines and specific “use of force” training to identify individuals who may exhibit symptoms associated with excited delirium.

Further, we were advised that police officers receive training regarding the use of force and on how to de-escalate situations. They must use force only if necessary, and the force used must be commensurate with the threat presented. In a fairly benign case, a simple verbal command may achieve the needed result. The use of force models consider tactical communication, physical control techniques, intermediary weapons and where warranted, lethal force.

RECOMMENDATION FIVE

That recognizing that experience is one of the best tools in learning how to communicate and deal with psychotic or delirious individuals and that junior staff learn from more experienced staff (while acknowledging the difficulties that exist in obtaining medical staff in Northern Manitoba) that as much as possible that less experienced staff in the psychiatric ward be partnered with someone having more extensive experience.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

This recommendation has been shared with the Provincial Mental Health Management Network. The Provincial Mental Health Management Network is comprised of the Mental Health Management from the 11 Regional Health Authorities throughout Manitoba, Manitoba Health, Selkirk Mental Health Centre and Eden Mental Health Centre.

Manitoba Health and Healthy Living later responded that:

The Management Network has taken the recommendation under advisement. They report that they deal with issues of recruitment and retention of nurses and other health professionals on a daily basis. Proactive recruitment activities are ongoing to manage the challenging health professional staffing needs of regions, especially in rural and northern settings.

Regional Health Authority (RHA) management report that pairing junior staff with more senior staff is recognized as a best practice and is always considered when possible, while also considering the challenges of recruitment, as well as restrictions of the Manitoba Nurses Union (MNU) environment. Further, restrictions are placed on staffing decisions when certain wards require a minimum number of male or female staff.

RECOMMENDATION SIX

Recognizing the role that education of the psychiatric patient by the nurses plays in his long term recovery and management of the patient's disease, that there is a high prevalence of F.A.S.D. in the Norman region and that there are patients who suffer from both F.A.S.D. and psychiatric illnesses, I recommend that a better understanding of the consequential features of F.A.S.D. should be provided to nurses, aids and physicians through their curriculum and by the attendance of compulsory training seminars thereafter.

MANITOBA HEALTH AND HEALTH LIVING RESPONSE

The recommendation concerning the education of nurses, aids and physicians through their curriculum is deferred to the Universities and Colleges that provide professional training. Manitoba Health does however provide ongoing professional development thereafter. Specifically regarding FASD training, Manitoba Health did organize workshops and Telehealth sessions for professional staff across Manitoba.

The Telehealth session was provided on two dates by Manitoba Health. The session covered the following:

- *Diagnostic information*
- *Prevalence rates*
- *Lifespan nature of FASD*
- *Secondary disabilities and challenges*

Approximately 130 individuals from nine of the eleven Regional Health Authorities attended the Telehealth sessions held on February 9, 2005 and March 2, 2005. One day workshops were provided in Brandon, Winnipeg (2 workshops) and The Pas. The workshops focused on the service and support needs of older adolescents and adults living with FASD.

Workshop facilitators provided FASD training to a wide range of stakeholders working with young adults with FASD in community-based agencies, as well as in the correctional, Employment and Income Assistance, and Child and Family Services systems. The one-day sessions were comprised of various activities – presentation, experiential interactive learning, videos and handouts.

Manitoba Health also obtained permission to tape a FASD presentation by Dan Dubovsky at the Western Canadian Conference, Adults with Fetal Alcohol

Spectrum Disorders, Circles of Sharing: Successful Journeys, held in Winnipeg on March 22, 2005. This tape has been offered to all RHAs for their ongoing professional development activities.

On March 12, 2010 Manitoba Health advised that in addition to the sessions on February 9, 2005 and March 2, 2005, the following has occurred:

- *FASD Training/Resources have been provided to health professionals and maternal child health program staff with information about alcohol and pregnancy, specifically:*
 - *The CD Rom Resource “What Doctors Need to Know About FASD”*
 - *Clinical practice guidelines (from the College of Physicians and Surgeons) for physicians on alcohol and pregnancy and FASD*
 - *Training and resources for the Healthy Baby and Families First programs and postnatal screening for alcohol use during pregnancy, a universal screen for alcohol use during pregnancy. Questions about alcohol use during pregnancy were added to the BabyFirst Screen January 01, 2003.*

- *The Addictions Foundation of Manitoba provides training on FASD to addictions and community workers.*

RECOMMENDATION SEVEN

The E.M.S. personnel are in charge of security at The Pas Health Complex and they may or may not always be there, especially if on a call. In this case because of the tremendous physical exertion that the personnel exerted in restraining Mr. Stevenson one cannot but wonder to what extent they could properly immediately thereafter carry out their usual life saving functions as paramedics both with that patient or if required for another call. The paramedics also seemed to view their two roles as somewhat in conflict. It may be wise for the Health Authority to reconsider the current situation and to consider the use of full time, properly trained security personnel. In any event I recommend that immediate training be provided to those who will be responsible for providing security at the hospital in the proper tactics to be used in restraining a violent individual. We heard from Staff Sergeant Mancini that such training is provided on a regular basis to the R.C.M.P. and that it may also be available through the law enforcement program at University College of the North. We heard that there is a close working relationship between the R.C.M.P. and the hospital and perhaps the restraint training could be carried out together.

NOR-MAN RHA RESPONSE

The Working Group determined that “Security Guards” would have a very limited role and we would be best served by staff with a more clinical background to assist in all aspects of care and yet allow flexibility to respond in the event of an emergent code situation.

A series of meetings were held with the Executive Director of Finance and Support Services, Executive Director of Human Resources and EMS staff in both Flin Flon and The Pas to discuss these issues and their relationship to management's performance expectations.

At the same time, a provincial review was conducted through our HR department and it was determined that rural facilities in Manitoba do not currently have "security guards" and that similar issues were being discussed provincially at various tables. Urban facilities (Brandon and Winnipeg) do employ Security Guards and it is our understanding that Brandon will be conducting a review of these services to assess effectiveness and efficiency.

Given these activities, our Working Group felt strongly that Security Guards would have a very limited role. We have implemented a number of other initiatives that will assist us in meeting the need for additional staff to respond to clinical situations such as an event of this type or other emergent code situations. These initiatives include: allocation of funding for two training assistants to conduct Non Violent Crisis Intervention training; development of a policy for 1:1 Constant Supervision for those clients that require close observation; a current budget request for an additional staff member on nights for the Acute Psychiatric Unit; and completion and approval of our Code White Policy and Procedure. We feel that the above initiatives will provide better support and guidance to staff in meeting their needs in dealing with difficult situations. This will be assessed as we continue with implementation of the Non Violent Crisis Intervention training. Discussions will be continuing with EMS staff and requests for further funding will be re-evaluated prior to the Health Plan submissions to Manitoba Health in June 2008.

The NOR-MAN RHA later provided the following status report:

- *Two 0.6 EFT Training Assistants were hired in March 2008. Both trainers attended the CPI (Crisis Prevention Institute) Non Violent Crisis Intervention "Train the Trainer" sessions in Regina in April 2008 and started staff education and training sessions in April 2008.*
- *As of the end of July 2008, 23 workshops have been held and we have trained a total of 224 staff at the Non Violent Crisis Intervention workshops.*
- *All staff certified in the Non Violent Crisis Intervention will require an annual refresher course and the instructors are required to complete a written exam every two years and attend an instructor excellence renewal course every four years.*
- *Development of a policy for 1:1 Constant Supervision was revised for those clients that require close observation.*
- *Given our limited funding and department requests for close to forty new positions for 2008/09, we were unable to allocate any funding for an additional staff member on nights for the Acute Psychiatric Unit. The Charge Nurse is*

responsible for assessment of client's needs and can request additional staff in the event that the situation requires.

- *Code White Policy and Procedure was approved and in place as of March 2008. Code White education was included in the Non Violent Crisis Intervention education and training.*

RECOMMENDATION EIGHT

We heard evidence that Mr. Stevenson's violent behavior involved the use of his hands, (i.e. throwing or swinging chairs, holding the upper body or wanting to punch Dan Pommer). If the use of some form of handcuff was available to the E.M.S. staff (or those who will be responsible for security) it may be that they could have secured Mr. Stevenson's hands and allowed him up from the prone position much more quickly and taken him into the seclusion room until the arrival of police. I recommend that such handcuffs be provided for the security personnel and that they be trained in the proper use of same. g

NOR-MAN RHA RESPONSE

A number of different types of mechanisms are available for physical restraint and we will be continuing to review these mechanisms in compliance with least restraint philosophy (Ex. Mesh security blanket, 4 point restraint, Pinel System of restraints, etc.). The Working Group conducted a literature review and a decision was made to not have handcuffs as a mechanical restraint.

The decision was made to incorporate the principle of Least Restraint in all clinical situations. In discussion with the EMS Manager and feedback from the provincial Medical Director, the only restraint that will be utilized by EMS staff will be the safety straps on the ambulance stretcher.

In the Acute Psychiatric Unit, the seclusion room will be utilized for clients that require close supervision. As mentioned previously, the education and training with Non Violent Crisis Intervention will provide staff with the necessary skills to deal with difficult situations.

The Provincial Health Programs and Services Executive Network (HPSEN) have requested that restraint policies be developed for both Acute Psychiatric Units and Emergency Departments. These requests have been directed to the respective Provincial Network groups for development.

The Provincial Mental Health Network forwarded a draft framework document for adult in-patient mental health services for circulation at the October HPSEN meeting. Each RHA was asked to review the document and the Chair of the Mental Health Managers sub-committee was invited to attend the December HPSEN meeting for further discussion on this document. The proposed

framework document was developed by the Mental Health Network based on work done in Saskatchewan.

In support of the document and to assist staff in managing violent patients, formalized non-violent crisis intervention education and training was recommended for staff. At the December HPSEN meeting, there was commitment on the part of the Regional Health Authorities to train staff in Non Violent Crisis Intervention. The minimum standard will be staff training in prevention management – each RHA will be individually responsible for implementing the requirement. Feedback from the December meeting will be incorporated into the framework document and the final document will be forwarded for HPSEN approval.

Our Mental Health Network representative will be asked to review and develop a policy on the principle of least restraint which is consistent with current practice. As well, further review of our existing Restraint Policies in Acute and Long Term Care will be conducted to ensure consistency. The distinguishing factor between this policy and the long term care policy is that the long term care policy was developed around preventing injury, for example, falls and/or wandering behavior and the mental health policy was intended for management of aggression in a designated psychiatric unit and was for use as a guideline for policy development.

The NOR-MAN RHA later advised my office that policy on the principle of least restraint has been developed and reviewed at the senior management level. We have been told that the Least Restraint Policy has been approved in principle, however further revisions are required. The RHA's review of the restraint policies in Acute and Long Term Care will be completed once the Least Restraint Policy has been approved.

It should be noted that my office had opened an Ombudsman Own Initiative (OOI) file relating to Manitoba Health and Healthy Living concerning the use of restraints and seclusion rooms in mental health facilities designated under *The Mental Health Act*. The Mental Health & Addictions Branch recently developed a provincial guideline regarding patient restraint and the use of seclusion rooms.

RECOMMENDATION NINE

There are too many in our society such as Mr. Stevenson who because of a disability be it schizophrenia, F.A.S.D. or a combination of both who are unable to obtain appropriate or any housing and this may exacerbate their condition leading to prolonged hospital stays at considerable expense or stays at the local jail or even provincial correctional facility. I recommend as suggested by Dr. Medd, Janet Modler, Lorette Doyle and Donna Jansen that a properly staffed and well funded supportive housing unit be operated by the department of family services and housing with involvement from community mental health for individuals in Peter Stevenson's situation.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

Government has developed a Cross Department Coordination Initiative (CDCI), an inter-departmental coordinating group representing Family Services, Housing, and Health to provide leadership in developing policy and a funding framework for housing vulnerable people. Three key areas have been identified: 1) Mental Health consumers, 2) Homeless and 3) Aging. The Advisory Committee will be working cooperatively with the CDCI to ensure that the capacity for housing and support services for individuals with mental illness in Manitoba is increased.

On July 29, 2008 Manitoba Health and Health Living advised that:

The Provincial Advisory Committee on Mental Health Housing and Supports completed its mandate in June 2008 and presented a position paper to Minister Irvin-Ross on June 18, 2008. This paper outlines the need for a range of housing options and support services with an emphasis on the development of “supported housing” options that provide integrated housing with support services attached to the individual. A series of considerations were provided to Government to improve the lives of vulnerable people living with mental illness.

In May 2008 CDCI received Treasury Board status for the SHOW initiative – Housing and Support Plan for Manitobans with Mental Health and Homelessness Issues. This is a joint initiative between the Department s of Family Services and Housing and Manitoba Health and Healthy Living. This new initiative is a nine point plan aimed at developing a range of housing options and support services for individuals with mental health issues, who are homeless or at risk of homelessness. The development of this plan was informed by the work of the Provincial Advisory Committee on Mental Health Housing and Supports and uses a Housing First approach. Projects currently proposed will include the development of transitional, supported and supportive housing options that provide affordable housing with support services. The 9 projects within the plan will add 70-80 new housing units, redevelop 200 existing units and will provide over 3000 individuals with better mental health and housing supports to assist them in maintaining a stable tenancy and support their mental health recovery. The projects will include the engagement of Regional Health Authorities, community service agencies and housing providers within urban, rural and northern communities. Planning on the proposed projects is in the preliminary stages. Although these projects provide additional capacities around mental health housing and support services, it should be noted that these projects are not targeted for individuals with dual diagnosis.

Future work of CDCI will include the further development of projects within the Show initiative and ongoing work around policy development and funding frameworks to support future improvements to housing and support services for individuals with mental health and homelessness issues. This will be done in partnership with the Departments of Family Services and Housing and Manitoba

Health and Healthy Living and in consultation with other government departments as required.

FAMILY SERVICES AND CONSUMER AFFAIRS RESPONSE

Current programs exist under the Supported Living Program for clients who first have a mental disability and who may also be living with Fetal Alcohol Spectrum Disorder (FASD). These programs include housing supports to help individuals with a mental disability live in the community. As well, in August 2004, an FASD Interdepartmental Committee was established to develop a provincial strategy which would include prevention, diagnosis and support of affected individuals across their lifespan. Recommendations of the committee have been put forward for consideration in the current provincial budgeting process.

On July 25, 2007 Family Services and Consumer Affairs advised that:

Further to the recommendations of the Fetal Alcohol Spectrum Disorder (FASD) – Interdepartmental Committee, on April 13, 2007, the Manitoba government announced new funding to implement a coordinated FASD strategy which will include a range of programs aimed at improving FASD prevention, detection and support. In consultation with experts and community stakeholders, the FASD strategy will expand on existing multi-departmental disability prevention activities, as well as service supports for people living with FASD, from birth through adulthood, for producing improved outcomes and helping individuals with FASD reach their full potential.

A new community-based resource centre called Spectrum Connections will be developed in Winnipeg initially to support transitioning youth (particularly those from the child welfare system) and adults with FASD to live more independently in the community. A total of \$550,000 has been budgeted for this initiative to provide resource information for families and mentoring or navigational supports to individuals to assist them in accessing social assistance, housing, education and training, recreation, family connections, and other social service supports available to them. As well, \$600,000 in funding is earmarked for hiring FASD specialists in order that child and family services authorities can better support agencies in providing services to families affected by FASD.

As part of the new FASD strategy, funding is also being targeted for increasing diagnostic services for adolescents, enhancing public education initiatives, training to improve service delivery for individuals with FASD, and expanding the Stop FASD program to three rural and/or northern communities. New funding will also go towards improving supports for women with addictions, adding more training supports for school divisions for educating students with FASD, and increasing research to guide the development of new programs and policies.

It should be noted that my office has an Ombudsman Own Initiative (OOI) file open with Family Services and Consumer Affairs and Manitoba Health and Healthy Living concerning the incarceration of vulnerable and high risk/high needs individuals in provincial correctional centres.

At the close of 2009 my office was advised of the following by Manitoba Health, Justice and Family Services and Consumer Affairs:

The Mental Health Court committee of the Provincial Court, chaired by the Chief Judge and comprised of representatives from the various stakeholders working with, and providing services to, persons with mental illness continues to meet and consider the requirements for a mental health court pilot of the Provincial Court. There is recognition that a main feature of a mental health court is the coordination of the various resources and supports available to persons with mental illness in order to provide the accused person with mental illness with an appropriate plan of support that will assist them in obtaining judicial interim release where the court has ordered same and/or having their court matters resolved appropriately. This will ultimately help keep persons with mental illness from being re-involved in the criminal justice system. The committee continues to examine the operations and outcomes of other mental health court initiatives in Canada.

Through our OOI file we will continue to monitor the situation regarding the incarceration of vulnerable and high risk/high needs individuals. At the time of the inquest there was no specialized court that could divert mentally ill or disabled individuals out of the criminal justice system into the community with the supports to treat their illness or disability.

There has been some positive movement this year. At the opening of the fifth session of the thirty-ninth Legislature of the Province of Manitoba, it was announced that the government will be introducing a mental health court to ensure that people with mental health issues receive appropriate support and supervision. My office will be following up on this initiative in 2011.

RECOMMENDATION TEN

The evidence indicated that Peter Stevenson was probably an alcoholic. We know that his consumption of alcohol was one of the factors that may have precipitated the confrontation which led to the delirium which eventually caused his death. Alcohol may even have had some actual physiological role in the whole series of factors which led to his death. Peter Stevenson had been through the local alcohol residential treatment program in The Pas three times and it was determined that he was not a suitable candidate for one of the other programs. He was not able to benefit fully from these programs in part because of the cognitive deficits he suffered as a result of his F.A.S. There are a large number of people in the Norman Region who suffer from F.A.S.D. and have significant substance abuse problems. I would recommend that a modified program be created for these individuals that takes into account the special learning difficulties often encountered by persons with F.A.S.D. and that it be provided within a residential substance abuse treatment facility.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

NOR-MAN RHA will be working with Rosaire House, residential addiction program in that area, to develop a modified program for individuals with FASD to ensure that they receive special programming needed.

Further inquiries were made with NOR-MAN in the beginning of 2010 and we were advised that:

NOR-MAN Regional Health Authority Mental Health and Addiction services prepared and submitted a joint proposal to Manitoba Health and Healthy Living to facilitate specialized programming for those clients with FASD in our residential treatment facility at Rosaire House. We were unsuccessful in obtaining additional funding for staff positions. Rosaire House does offer service to this specific high need population and will continue to try and facilitate recovery through modifying their regular program to try and meet the specific needs of this group.

Since so many of these clients experience substance abuse disorders, it is reasonable to assume that they appear in addiction treatment settings. Because this is a very difficult and needy group of clients, they do not participate well in sessions, can be disruptive and require constant attention. We are able to modify our regular program to try and meet the client's needs. Clinicians are more flexible in their expectations of the client and are more understanding when the client does not meet the expectations. If clients leave the group sessions early, they are more flexible in scheduling the sessions. Although we do as much as possible to address individual client issues with small group work, our only recourse at present when the client gets too abusive or aggressive, is to ask the client to leave.

The population of adults with FASD and substance abuse disorder require interventions of much longer duration and much shorter intensity than the general population. Rosaire House intake protocols already identify substantial numbers of clients who fit into this category. Our proposal for additional staff would enable us to designate five residential care beds to offer longer or interrupted stay programs to those clients with learning disabilities or impulse control issues such that traditional 28-day programming is usually unsuccessful. We would be able to provide community transition support and extended outpatient services that would enhance reintegration into the community for those clients with FASD/ARND. Our request for funding was not successful in obtaining additional funding for staff positions at this time.

It would appear that the Rosaire House is making an effort to provide a modified program for individuals with FASD to ensure that they receive the special programming needed. As pointed out in their response, it would seem that the level of service they can provide is contingent on existing resources and future funding.

Budget requests are completed by program managers and reviewed by Senior Management of the NOR-MAN RHA and those approved by Senior Management are prioritized and submitted to Manitoba Health by June 1 of each year. Submissions for the June 1, 2011 Health Plan are requests for the fiscal year 2012-2013.

RECOMMENDATION ELEVEN

We heard evidence that the hospital made certain changes subsequent to Peter Stevenson's death. In particular there is now oxygen available on the psychiatric ward, a proper stretcher is available on the 4th floor very near the entrance to the psychiatric ward, and that there is regular, daily testing of the suction device. Whether or not having these medical devices available would have done anything to change the outcome in Peter's case once he was arrested cannot be answered. (The important thing is to recognize and attempt to medically deal with excited delirium before it reaches that stage). I commend the hospital for making those improvements and recommend that they remain in place.

NOR-MAN RHA RESPONSE

We appreciate Justice Gregoire's commendation. It is our intention to maintain these improvements and continue to monitor the situation.

RECOMMENDATION TWELVE

There is so much that is unknown about what role clozapine may have played in Peter Stevenson's death. I recommend that further, scientific study be encouraged in order to determine if possible how clozapine contributed if at all to sudden cardiac death. Mr. Thurmeier, the psychiatric pharmacist expert stated that he would be doing more and closer heart monitoring for his patients on clozapine. I believe that this would constitute good practice and I recommend that weekly E.K.G. heart monitoring be carried out for all patients who are on clozapine during the titration phase and for a reasonable period thereafter to determine if clozapine is having a noticeable change to the patient's heart.

MANITOBA HEALTH AND HEALTHY LIVING RESPONSE

Health Canada is responsible for regulation of pharmaceutical products sold in Canada. Specific warnings, prescribing directions and/or monitoring recommendations fall under the auspices of Health Canada in conjunction with the product manufacturer.

The recommendation should be referred to Health Canada.

My office made further inquiries with Manitoba Health and Healthy Living and confirmed that they have referred this recommendation to the Canadian Adverse Reaction Monitoring Program with Health Canada.

RECOMMENDATION THIRTEEN

Peter was being helped by Walter Mink the direct service worker. Mr. Mink acknowledged that he didn't have a sufficient awareness of Mr. Stevenson's condition and felt overwhelmed by the situation. I recommend that direct service workers receive adequate training in order to be able to appreciate the actual needs of their clients and to be able to assist them accordingly.

FAMILY SERVICES AND CONSUMER AFFAIRS RESPONSE

Service Delivery Support staff are reviewing the scope of the current orientation offered to direct service workers, concerning complex needs clients, to determine with the Regions whether enhanced orientation and case specific support should be developed. Staff have contacted the Regions to request feedback about the use of documents that are used to collect information about a client which are then used to assist the resource coordinator in matching a direct service worker to a participant. Other information requested from the Regions includes the role of the resource coordinator in relation to the client, and the role of the resource coordinator in relation to the caseworker.

On July 25, 2007 Family Services and Consumer Affairs advised that:

With respect to orientation for direct services workers, I can advise that a number of policies, directives and forms have been developed and implemented to increase overall effectiveness of this workforce. Improvements have been made to communications, general orientation and participant specific orientation provided to direct services workers.

In addition, the Disability Programs and Employment and Income Assistance Division has contracted with Red River College to develop an orientation package for direct services workers. The Orientation Modules being created by Red River College are expected to be completed by the end of August 2007. Departmental staff will be developing a delivery strategy for the introduction of these new modules in the fall of 2007, as well as continuing to examine other areas of orientation that may require further development.

On October 31, 2007 Family Services and Consumer Affairs advised that:

I can advise that the guide was shared with Resource Coordinators and Program Managers from the regions on October 25, 2007, along with an implementation plan to assist the regions in using the guide. In addition, we continue to work on improving the general orientation and participant-specific orientation that direct service workers receive through new and revised policies and procedures.

The Guide that was provided to our office includes information in the following areas:

- Promoting professionalism

- Promoting Quality of Life in the Community
- Promoting Health and Wellness
- Understanding Disabling Conditions
- Promoting Effective Communication
- Promoting Positive Perspectives on Behavior
- Promoting Learning for Individuals
- Promoting Successful Relationships with Families
- Understanding Human Development

Based on our review of this matter, it would appear that Manitoba Health and Healthy Living, Justice, Family Services and Consumer Affairs and the NOR-MAN Regional Health Authority have given reasonable consideration to the above noted recommendations. As such, our files concerning the Peter Stevenson Inquest Report have been closed.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

cc: Mr. Milton Sussman, Deputy Minister of Health
Mr. Jeff Schnoor Q.C., Deputy Minister of Justice
Mr. Grant Doak, Deputy Minister of Family Services and Consumer Affairs
Mr. Drew Lockhart, CEO NOR-MAN RHA
Dr. A. Thambirajah Balachandra, Chief Medical Examiner

