

Manitoba Ombudsman

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July 20, 2018

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

Inquest into the death of Ronald Bobbie
Public Body: Manitoba Health, Seniors and Active Living
Our File No: 2017-0240

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 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 recommendation into the death of Mr. Ronald Bobbie on September 26, 2014. The June 13, 2017 inquest report of the Honourable Judge Lindy Choy was released on June 16, 2017.

Mr. Bobbie, 59, was an involuntary resident of Forensic Unit 14 at the Selkirk Mental Health Centre (SMHC) at the time of his death. He died on September 26, 2014, from drowning in the Red River, north of the Redwood Bridge in Winnipeg.

The Honourable Judge Choy made a recommendation in the inquest report, which was directed to SMHC (a psychiatric facility under Manitoba Health, Seniors and Active Living or MHSAL), as follows:

Recommendation

With respect to patient monitoring on Selkirk Mental Health Centre (SMHC) Area 14, nursing staff should be equipped to enable effective monitoring of patient ingress and egress. This may be implemented by physical changes to the ward or staffing changes or both.

We followed up with MHSAL regarding their implementation of the recommendation and on February 6, 2018, we received the following response:

...

In keeping with mental health recovery orientated practices, SMHC advises that maintaining patients in the least restrictive environment is appropriate and a priority. Area 14 is currently an open patient care area and the patient population has been assessed by the treatment team as appropriate to be granted greater responsibilities and liberties.

Notwithstanding the intent to promote recovery practices, SMHC acknowledges that forensic patients may pose increased risks, including non-compliance with treatment, breach of disposition orders of the Criminal Code Board of Review, failure to return from passes or leave the institution without proper verification, and/or exhibit other behaviours that may put themselves or others at risk.

Subsequent to the inquest, SMHC worked with the nursing staff on Area 14, and determined that the most appropriate response was to undertake a policy change in order to manage patients with similar risk and characteristics of the individual who is subject of the inquest. SMHC has revised the relevant policy, delegating authority to nurses to return forensic patients to Area 15, the locked Forensic Area, until assessed by the psychiatrist in cases where patients' characteristics suggest that there may be increasing risk. This is now a delegated authority to nursing staff, pending assessment by the attending psychiatrist.

...

The policy became effective April 2017 and has been subsequently utilized on two occasions with success.

MHSAL is satisfied that this action is an appropriate response to the Bobbie Inquest recommendation.

...

MHSAL's response to our office included a copy of the referenced policy, which is titled 'Patient Care: Transfer/ Discharge of Forensic Patients'. We reviewed the policy and noted that it addressed the substance of the recommendation. We also note that SMHC's action regarding the policy review in April 2017 was pro-active, as it predated the release of Judge Choy's report on the inquest.

As MHSAL has provided a full response to the inquest recommendation, we will conclude our monitoring of the implementation of the recommendation.

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

Yours truly,

A handwritten signature in black ink, appearing to read 'CP' followed by a horizontal line.

Charlene Paquin
Manitoba Ombudsman