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Via Courier

January 19, 2015

C15-008

Ms. Mary-Lou Patey

Dear Ms. Patey:

Re: **Your request for review of the decision of Dr. William Lucas regarding an Inquest into the Death of Joshua Alvin PATEY**
Date of Death: June 12, 2012
Our File: 2012-7219

This letter is in response to your request that I review Dr. William Lucas' decision not to hold an inquest into the death of your son, Joshua Alvin Patey. Thank you for taking the time to provide reasons supporting your request for the review and for providing Dr. Martha Burt's report.

In reaching my decision, I have reviewed the documents outlined in Appendix A - List of Documents. Also, there are key things that are essential in a review when an inquest has previously been denied, including: statutory criteria; reasons for the review; previous investigation; and an analysis of the decision of the Deputy Chief Coroner or Regional Supervising Coroner.

The Statutory Basis for this Review

When making a decision regarding whether or not an inquest should be held the coroner refers to sections 10 and 20 of the *Coroners Act* (see Appendix B) that set out the criteria that must be considered. I think it is very important for me to explain clearly what the purpose of an inquest is and, as importantly, what an inquest is not.

An inquest is a public hearing conducted by a coroner before a jury of five community members. Inquests are held in the public interest for the purpose of informing the public about the circumstances of a death. It is hoped the jury will make recommendations that if implemented, may prevent future deaths in similar circumstances, thereby advancing public safety.

Each inquest has a defined scope of issues which is informed by the earlier investigation into the death. The evidence presented and the issues explored are limited by the defined scope at each inquest. Inquests are specifically focused on issues identified during the investigation, as opposed to a re-investigation of the death.

No one is on trial at an inquest and the jury cannot make findings of guilt or blame, or imply responsibility on any person(s) or agency, organization or other entity. The inquest is intended to make the facts of a death public and to identify, if possible, how similar deaths can be prevented.

The Request for an Inquest

You asked for an inquest into your son's death. The reasons that you believe an inquest should be held were provided through verbal and written correspondence with the Office of the Chief Coroner (OCC). Dr. Lucas provided his response to your request in his February 13, 2014 letter.

Your February 25, 2014 letter to me indicates that you are requesting an appeal of Dr. Lucas' decision to not hold an inquest into the death of your son. You asked that I not proceed until a pending review of the post mortem examination findings and tissue samples by an independent pathologist is complete.

On December 9, 2014, in further correspondence to me, you request that I move forward in my consideration for an inquest into your son's death.

In your letters of February 25, 2014 and December 9, 2014, (supported by a copy of your submission to the Health Professionals Appeal Review Board (HPARB) dated November 25, 2012), you provide the following reasons to support your request that Dr. Lucas' decision to not hold an inquest into the death of your son be reviewed:

1. The circumstances leading up to the death of your son mandate, under the *Coroners Act,* that an inquest be held based upon:
    a. the health care professionals/hospital had no intention of letting him leave with or without his permission.
    b. Joshua was detained.
2. There is public interest for an inquest into the death of your son.
3. An inquest would be of great benefit to ensure the proper care and safety of future patients in this situation; that is, the many medical errors and gross negligence in the care provided to your son.
    a. An outline of your care related concerns was provided in your February 25, 2014 letter. The submission to the HPARB included additional discussion and context about these concerns.

4. Physicians need to realize that the first priority should be physical well-being with mental health being secondary.

5. There is a cover up on the part of the hospital and the doctors involved.

A non-care related specific question included in the letter of February 25, 2014 was:

1. Why did Dr. Lucas not get a statement from the nurse as to what they administered to Joshua?

The Decision of Dr. William Lucas

Dr. Lucas determined that criteria for a mandatory inquest were not met.

He further determined that it would not be in the public interest to hold an inquest based on the purposes of an inquest set out in s. 20 of the *Coroners Act* because:

1. The statutory requirements regarding identity, time and place of death, cause of death and manner of death had been satisfactorily determined and that an inquest jury would be unlikely to provide different answers to these mandatory questions.

2. Exploration of the issues identified and provided to support the request for an inquest was not felt to be of benefit to the public interest. There was no perception of a significant public safety issue or systemic failure identified during the investigation and subsequent review.

3. A jury would not be able to offer additional recommendations aimed at the prevention of deaths in similar circumstances.

4. Dr. Lucas determined that an inquest cannot be the vehicle for making persons, including health care professionals, responsible or accountable for the death because of the prohibition on the assignment of legal responsibility by coroners and coroners' juries.

Analysis

Approach of Dr. Lucas

In conducting my review of the decision of Dr. Lucas, my task is to determine the following:

1. Did he properly consider the required matters under s. 26(1) of the *Coroners Act*? i.e. the reasons provided by you through written and verbal correspondence with the Office of the Chief Coroner.

2. In his consideration of these matters, did Dr. Lucas use section 20 of the *Coroners Act* as required?

After reviewing Dr. Lucas' February 13, 2014 letter to you, I note that he set out the criteria he used to (1) determine if the circumstances of the death met criteria for a mandatory inquest and (2) to determine whether a discretionary inquest would be held.

- He stated that the death did not meet criteria for a mandatory inquest.
- He stated that the required matters had been determined.
- He considered whether or not a jury could be expected to make useful recommendations beyond those already made during the investigation and subsequent review by the Patient Safety Review Committee (PSRC).
- Finally, he noted that the use of an inquest as a vehicle to ensure accountability is not permitted under the legislation.

Dr. Lucas has logically examined your issues within the scope defined by the *Coroners Act* and I find that his analysis is sound.

Reasons to Support Request for Review of the Decision of Dr. Lucas

Additionally, I have carefully reviewed the reasons you provided in your February 25, 2014 and December 9, 2014 correspondence, specifically:

1. *The circumstances leading up to the death of your son mandate under the Coroners Act that an inquest be held based upon:*

    a. *the health care professionals/hospital had no intention of letting him leave with or without his permission.*

    b. *Joshua was detained.*

I have carefully reviewed section 10 (4.7) and *Regulation 180/13* of the *Coroners Act* to inform my consideration.

An Application for Psychiatric Assessment (Form 1) under the *Mental Health Act* was completed shortly after Joshua's arrival at the Cambridge Memorial Hospital (CMH). A Form 1 allows the detention and assessment of a patient in a psychiatric facility/hospital for up to 72 hours. This is characterized as an involuntary admission and Joshua was therefore detained in the CMH at that time.

Psychiatric assessment of Joshua was completed on June 6, 2012. The Form 1 was withdrawn as the assessing psychiatrist reportedly had belief that Joshua was not suicidal at the time of the June 6, 2012 assessment. From that time forward, Joshua was a voluntary patient at the CMH.

Joshua was subject to intermittent physical restraint while admitted in the CMH Intensive Care Unit (ICU) over the days prior to his death. Chemical restraint was also used during the ICU admission. During this time, he was a voluntary patient as defined in the context of a psychiatric admission.

He was not subject to either chemical or physical restraint at the time of his death on the medical ward shortly after his transfer from the ICU.

The legislative criteria present in the *Coroners Act* specifically, physical restraint and detention in a psychiatric facility, were considered within the context of the circumstances of Joshua's death. At the time of Joshua's death he was neither physically restrained, nor detained in a psychiatric facility, as defined by the *Coroners Act* and *Regulation 180/13*. The circumstances of Joshua's death do not meet the legislative criteria for a mandatory inquest.

2. *There is public interest for an inquest into the death of your son.*

The decision to conduct an inquest is based upon the outcome of the death investigation. The decision is not based on the quantity of media coverage, phone calls or letters.

Specifically, when considering how the OCC considers desirability for the public being fully informed (*Section 20(b) of the Coroners Act)* there is no objective measure of what is "desirable." The section 20 (b) desirability test in the *Coroners Act* must be read in the context of the term "public interest" as interpreted by the courts, and the statutory purposes of the inquest under section 31.

It is difficult to "quantify" desirability, as the determination is subjective and established on a case by case basis on individual factors identified during the death investigation. Desirability is looked at in a broad context including:

- The desirability consideration used to guide whether to proceed with a discretionary inquest must be made in the public interest versus a private interest.
- The desirability to decide on a discretionary inquest should be measured by whether the inquest has the potential to advance public safety and have a significant impact on a substantial population i.e. a community, an industry or the provincial population.
- One of the considerations is whether the potential issues arise from investigation of the circumstances of death are known to the public or, alternatively, if there is public misunderstanding about particular issues and this misconception requires clarification to enhance public safety. There may be limited desirability to fully inform the public when the issues are already broadly known in the public realm.

In addition to desirability, other factors must be considered in deciding whether an inquest will be called.

Some of the other factors may limit the ability to proceed with an inquest even if there is a degree of desirability. A key fundamental factor is that the purpose of the inquest is not to find blame or guilt. Issues of potential blame or fault finding have no place in the inquest process and must be addressed in alternate settings. Ultimately,

the underlying foundation of an inquest is death prevention. In addition, the inquest arises from issues identified during the actual death investigation itself with purpose of exploring the issues further, not to re-investigate the death.

The PSRC reviewed the circumstances of Joshua's death within the context of the care issues that you have identified. The committee did not identify systemic public safety issues. The majority of the issues you have highlighted in your past and recent correspondence are subject to medical care practices of individual physicians, practice care guidelines and/or polices.

My review of the case material did not identify systemic issues that would lead me to believe that an inquest would have a significant potential to advance public safety by having a significant impact on the Ontario health care system. In contrast, the investigation (and the reasons you provided) indicate that if held, an inquest would be limited in scope to focus on an individual health care facility and individual health care practitioners.

In addition, your suggestion to focus on many medical errors within a context of gross negligence does not have a place in the inquest system – health professional regulatory bodies and HPARB are the correct forums for this review.

3. *An inquest would be of great benefit to ensure the proper care and safety of future patients in this situation; that is the many medical errors and gross negligence in the care provided to your son*

    a. *An outline of your care related concerns was provided in your February 25, 2014 letter. The submission to the HPARB included additional discussion and context about these concerns.*

In Ontario, a Coroner's Inquest will explore issues identified during the investigation of the death, typically those of a systemic nature, which may benefit from recommendations to reduce the likelihood of future deaths under similar circumstances. Issues that appear to be isolated to the actions or inactions of individuals are typically not areas that are explored at an inquest, particularly if exploration of these issues may be potentially fault finding or blaming. Professional competency would be an example of an area that would not typically be explored at an inquest. Oversight of health care professionals is the responsibility of the health care facility where the health care professional practices and, if a physician, the College of Physicians and Surgeons of Ontario (CPSO).

The CMH undertook a detailed review of the circumstances surrounding the death of your son. The hospital review prompted a number of quality improvement changes with the goal to improve patient care. The hospital would be in the best position to provide insight into their review and the resultant changes.

The majority of the issues that you have identified in your February 25, 2014 letter and the HPARB submission provided as support for your December 9, 2014 letter pertain to medical care practices of individual physicians, practice care guidelines

and/or policies. Non-compliance with policies or issues with care provision practices in individual health care professionals with a view to find fault or incompetence do not fall under the jurisdiction of the OCC. There are other avenues to address these issues by those in authority specifically, professional licensing bodies such as the CPSO.

I understand that you have expressed similar concerns to the CMH, CPSO, and the College of Nurses of Ontario (CNO).

Within a public safety mandate, the OCC provides reasonable and practical recommendations in response to issues that are identified during death investigations. As others have greater expertise in specific areas, i.e. effective messaging to physicians or practice guidelines for practitioners; recommendations are made to organizations with specific expertise to allow effective response. Essentially, as experts in death investigation, the OCC identifies potential issues that may benefit from review and change that could reduce or prevent future deaths in similar circumstances. Those issues are brought to the attention of those in a position to evaluate the issue and potentially facilitate change.

The PSRC undertook a review of the circumstances of Joshua's death. While the committee did not identify issues of a systemic nature the committee did make recommendations to enhance patient care both locally and provincially thorough direction of their recommendations to the CMH, the Ontario Hospital Association (OHA) and the Ontario Medical Association (OMA).

4. *Physicians need to realize that the first priority should be physical well-being with mental health being secondary*

It is a commonly held principle in the health care profession that serious physical issues must be primarily addressed. Having said that, treatment of physical and mental health issues can and often do occur concurrently. Given the common knowledge of these principles in health care, this is not an area that requires exploration at an inquest.

Concerns were expressed about the approaches of individual health care professionals. These are typically not areas that are explored at an inquest particularly, if exploration of these issues may be potentially fault finding or blaming.

5. *There is a cover up on the part of the hospital and the doctors involved.*

I understand you believe that some information has been purposely withheld, inaccurately provided or covered up. I do not share this concern.

In your February 25, 2014 letter you asked: *"Why did Dr. Lucas not get a statement from the nurse as to what they administered to Joshua?"*

Death investigations are completed by a coroner to meet the legislative requirements set out by the *Coroners Act* ensuring that the circumstances of the death are understood to the extent possible so that no death is overlooked, concealed or ignored.

Each investigation is unique and tailored to the degree determined necessary. This is directed by issues identified during the investigation to meet the purpose defined by legislation. Investigations are completed in the public interest and may not include evaluation of issues thought to be of private interest.

It was my understanding that the focus of your question about seeking further information from the nurses was based upon your belief that Haldol was administered. Based upon my review of the available materials, this issue was carefully reviewed by the hospital and PSRC. No specific concerns likely remained that would have prompted Dr. Lucas to request further information from the nurses. I concur with this approach.

Overall Consideration

Having carefully reviewed the information available, I am satisfied that the answers to the mandatory five questions required by s 20 (a) of the *Coroners Act* have been answered and are accurate. These are detailed in the correspondence previously provided to you. I do not believe that an inquest jury would provide greater accuracy or insight. I note that Dr. Martha Burt concurred with the findings of the coroner's investigation.

Regarding *section 20 (b)* of the *Coroners Act,* when deciding whether to call an inquest, the coroner must consider the desirability of the public being fully informed of the circumstances of the death through an inquest, bearing in mind that inquests are held to serve the public interest. For the purposes of administration of the *Coroners Act*, this office considers actions in the public interest to be those which advance the public good, especially as these relate to public safety.

This case has been thoroughly investigated. It is my opinion that there are no systemic public safety issues identified during the death investigation. The case was reviewed by the PSRC who provided a reasonable response through recommendations that are within the context of the investigation findings and the concerns brought to their attention through your correspondence.

Therefore, I conclude that Dr. Lucas correctly determined that there would not be a benefit to the public being further informed of the circumstances of the death through an inquest. This conclusion is not meant to imply either approval or criticism of the care your son received. An inquest jury cannot make any finding of legal responsibility, as set out in s. 31(2) of the *Coroners Act.*

The final matter considered by Dr. Lucas was whether or not an inquest jury could make recommendations directed to the avoidance of death in similar circumstances, recognizing that recommendations had already been provided by the CMH and PSRC.

The CMH independently reviewed the circumstances of the death and made a number of quality improvement changes and likewise, the PSRC provided recommendations to the CMH, OHA and OMA.

I do not believe that a jury composed of laypersons would be better positioned to provide further recommendations. In my view, Dr. Lucas made a correct determination in this regard.

I conclude from the foregoing that Dr. Lucas correctly approached your request for an inquest as set out in the *Coroners Act*. His decision is, in my opinion, reasonable in that it was reached from his thorough analysis.

While I am aware that you have continued concerns and questions, these do not relate strictly to the inquest and its purposes. You are aware that there are other avenues which are appropriate to deal with legal responsibility.

Decision

I have reviewed the decision of Dr. Lucas and considered this within the context of the death investigation, the available materials and information provided through your correspondence. I find that the process undertaken by Dr. Lucas of arriving at his decision was reasonable. I further find that the decision is reasonable, and therefore, will not order an inquest.

Conclusion

In closing, please accept my sincere condolences on the loss of your son on behalf of the OCC. The time you took to carefully prepare and present your information was valuable as it helped inform my review. As you have seen by the length of this correspondence, it was a very comprehensive process. If you have questions about the approach I have taken or would like me to elaborate on my rationale for the decision not to hold an inquest, I am willing to have a discussion with you either by phone or in person.

I am aware that you have a number of concerns regarding issues of care. I urge you to continue communicating with the hospital regarding the outstanding questions for which you are seeking answers or clarification.

Sincerely,

Dirk Huyer, MD
Chief Coroner for Ontario