Opening

I would like to state that even though I am here to appeal the CPSO decision I hold little hope of anything being resolved. This board is only to placate the average person into believing we have rights in this country. After all, the Health Professional Appeal and Review Board has no actual power to change decisions made by the CPSO.

Since the records can be quite confusing to us laymen and they are not in the correct order of events during my son's care, I have tried to put into chronological order the way his care went as I was present during almost all of his stay.

My son, Joshua, died on June 12/12. He was a talented writer, avid sports fan, great cook and he was always the comedian in the room, making everyone laugh. Unfortunately he was crying on the inside. He was diagnosed with bipolar disorder and was on medications for this since 2006. I fought hard to get him the help I thought he needed. About 6 months before his death the psychiatrist put him on Abilify. I know this drug led him to attempt suicide by taking an overdose of his prescription medications. I have learned that unfortunately a lot of the medications prescribed have more dangerous side affects than any benefits they may have. They are routinely prescribed and not monitored very closely. One of the side effects of Abilify is suicide. It did not make sense that he would do this as his life was going relatively well at the time. He had just been published in a local magazine and was working with another. In all his troubled times he had never mentioned suicide.

The actual cause of death was pulmonary embolism or in layman's terms, blood clot to the lung which most definitely was caused by the treatment he received by not one, but three doctors. He was hospitalized for 8 days and the medications he ingested were long gone out of his system.

Although he took the overdose, he was not responsible for the improper care he received after being admitted to the hospital.

Yes I have been devastated by my son's death. It is the most brutal thing that can ever happen to anyone. I firmly believe if he had received the proper treatment he would still be here with us today.

In hindsight, I now believe Joshua would have had a better chance if we had just made him stick his finger down his throat and vomit up the medications he took. This is the old fashioned way and it seemed to work well.

It is easy to blame the patient especially when they have attempted suicide, but the doctors are responsible for the care they receive in the hospital not the patient.

Investigation:

I am deeply disappointed that my complaint regarding the missing pharmacy records for the Haldol prescribed by two doctors on June 6/12 was not investigated properly. Since everything that is ordered by the doctors is supposed to have a pharmacy record, whether it is administered or not. I suggested that they question the nurses involved and this was never done. It seems very strange that these are the only two pharmacy records that seem to be missing. Both show in the records that they were indeed faxed to pharmacy. At my last meeting with the hospital regarding this I was told and I quote "maybe they fell off the back of the fax machine." Really? More than six hours apart and both fell off the back of the fax machine. Again I would suggest the nurses be questioned as to what they administered to my son. I have yet to receive a satisfactory explanation for the missing records.

Independent opinion:
I consider the so called independent opinion to be invalid for the following reasons.
First of all, there can be no independent opinion from any doctor in Ontario since they are all members of the CPSO.
Secondly, if there are four doctors on the panel reviewing my complaint, why would they need an opinion from another doctor. Are they not qualified to judge the records for themselves?
Thirdly, I was told that the doctor would remain anonymous, however since this doctor had access to all names in question, he or she could have easily contacted the doctors in my complaint. As far as I am concerned they could be classmates.
Fourthly and most importantly, any document with the names blacked out would never be allowed in a court of law. For all I know this could have been written by anyone such as a lawyer, the doctor's secretary or even possibly the investigators themselves.
For the reasons above, these documents should not even be allowed to have any bearing on this appeal.

I also feel that since Poison Control are the experts in cases of overdose, the investigators should have contacted them for the following reasons.

1. To ask what their recommendations would have been if Dr. N had contacted them when he was made aware of the rising levels .

2. To give their opinion as to whether Josh's symptoms were consistent with rising ammonia and valproic acid levels.

2. To ask why Haldol should not have been prescribed and to look at the records to determine whether Josh showed any signs of receiving this.

This is the independent opinion they should have got and yet this was totally ignored.

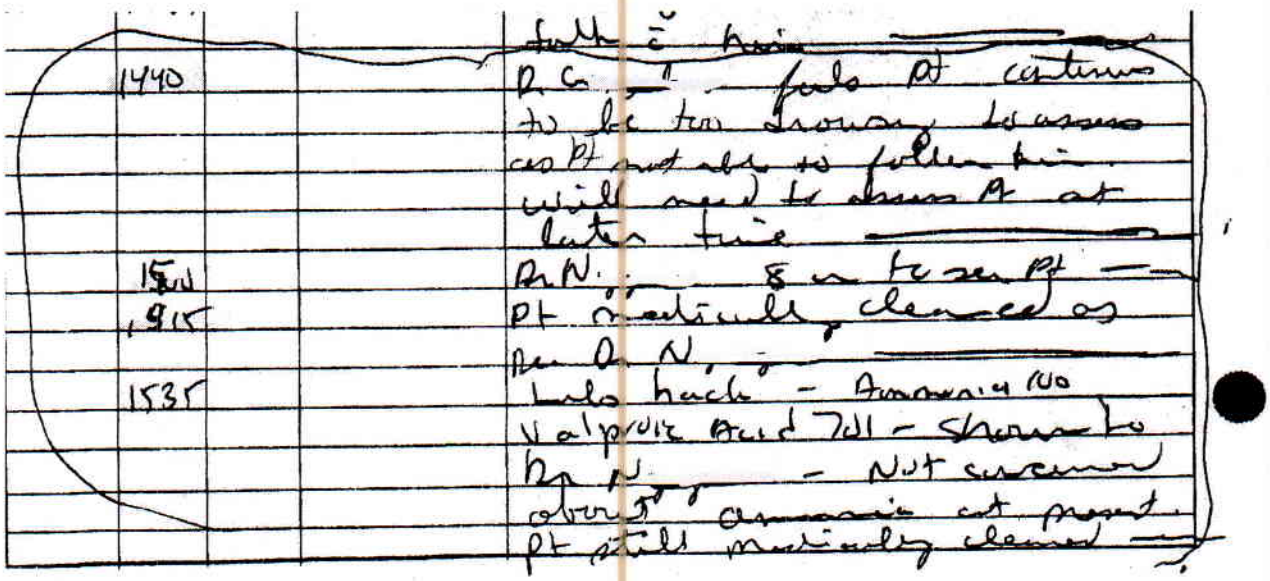
Dr N. - File #14-CRV-0102

On June 5/12 my son Joshua took on overdose of his prescription medications and called myself and his father shortly afterward. We of course took him to the local hospital immediately. Once there Dr L. in the Emerg called poison control and went with their recommendations, which is protocol. After all, Poison control are the experts. I want to let you know that the most dangerous thing about taking an overdose, like Joshua did, is the rising ammonia and valproic acid levels in the bloodstream. This is very important to remember. He was given an antidote called Levocarnitine. Blood work was taken every three hours and was sent by taxi to another hospital for analysis as they could not do it there. They also had to get the antidote from another hospital as apparently they did not stock it there. It is now obvious to me that they were neither equipped or competent to handle his treatment. Sadly he was passed on to another doctor in the emerg and after about 26 hours his blood work taken at 5:10 am. on June 6 came back as normal. Doctor N. who was now the doctor in charge of Josh's care discontinued the levocarnitine antidote at about 10:30 am after reviewing the blood work results from 5:10 that morning. Still blood work continued to be drawn and sent out for analysis. At 2:40 in the afternoon Dr G., the psychiatrist in the emerg tried to interview him but said and I quote "patient continues to be too drowsy to assess as patient not able to follow him - will need to assess patient at a later time."

Now just 35 minutes later at 3:15 pm Dr. N. came in and medically cleared Josh.

At 3:35 he was shown the results of the blood work taken at 1:05 that afternoon showing Josh's ammonia level to be 100 up from 18 in the morning, quite a bit above normal and his valproic acid level to be 701 which is at the top of the acceptable level. Again I will quote what Dr. N. said at this time "not concerned about ammonia level - patient still medically clear". He should have contacted poison control and discussed this with them as is protocol but he did not. He did not follow protocol. I do not care how many initials a doctor has after his name, he can not presume to know better than the experts at Poison Control who deal with this 24/7.

SEE FOLLOWING RECORD



Since the main concern when someone takes this type of overdose is the ammonia levels in the blood, I still can not understand why on earth Dr N. would proceed to medically clear my son. Also if Dr. G., the psychiatrist could not interview my son just 35 minutes earlier, how is it that he could be medically clear. This was not human error or an innocent mistake. This was willful criminal negligence on the part of Dr. N. Dr. N. claimed Joshua presented medically well. Presenting medically well means that if you outwardly look well than you present medically well. You could be racked with cancer and still present medically well. Then he went on to state that he was more concerned about my son's mental health than physical state and that is why he did this. Well, what good is mental health treatment if you are physically dead. Physical well being should be the first priority. Besides this, Dr. N. is not a qualified psychiatrist and had no business presuming what Joshua needed as far as mental health treatment. He is only a medical doctor and was only responsible for treating Joshua's physical well being.

He also claimed that the blood work taken at 1:05 pm was an anomaly but it would seem more likely that the one taken at 5:10 am showing the levels to be normal was the anomaly since it was the only one showing normal values. At the very least he should have waited for the next blood results to see if it continued to rise as well as consulting Poison Control the experts.

See the blood work results next.

4A DAILY SUMMARY 5 DAY BACKUP REPORT

LOCATION
Ext.Treatment Program (ER) O

Patient: PATEY,JOSHUA ALVIN Acct #AC001655/12 Unit #016955 (Continued)
Reg Dr: N

CHEMISTRY

Date	6 JUN 12				
Time	0710				Reference Units
Glucose Random	4.1				mmol/L
Urea	1.7 L				(3.2-7.1) mmol/L
Creatinine	79				(58-110) umol/L
Sodium	142				(137-145) mmol/L
Potassium	3.5 L				(3.6-5.0) mmol/L
Chloride	111 H				(98-107) mmol/L
Bicarbonate	26				(22-30) mmol/L
Anion gap	5				(4-12) mmol/L

ENZYMES

Date	6 JUN 12				
Time	0710				Reference Units
Amylase	60				(30-110) U/L
Total Bilirubin	12				(2-19) umol/L
Conjugated Bili	0				(0-5) umol/L
Alk Phos	53				(38-126) U/L
ALT	29				(21-72) U/L
AST	19				(19-48) U/L

CHEMISTRY REFERENCE LAB TEST RESULTS

Date	6 JUN 12				
Time	0130	0510	1305		Reference Units
Ammonia	323(@a) H	18(@a)	100(@a) H		(7-35) umol/L
Valproic Acid	(A) H	(B) L	701(@a) H		(350-700) umol/L

(A) 1044 H
See also (@a)
(B) < 69 L
See also (@a)

NOTES: (@a) Guelph General Hospital, 115 Delhi Street, N1E 4J4

It clearly shows ammonia levels continuing to rise. This is after he was transferred to Mental Health floor.

RUN DATE: 09/07/12
RUN TIME: 0724
RUN USER: HBUI1

CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd., Cambridge Ont. N1R 3G2
519-621-2333 ext.2210

PAGE 1

4A DAILY SUMMARY 5 DAY BACKUP REPORT

LOCATION
Mental Health I

PATIENT: PATEY,JOSHUA ALVIN
DATE OF BIRTH: 04/11/86
REG DR: G

ACCT #: MA000084/12 LOC: 5BMH U #: 016955
AGE/SEX: 25/M ROOM: 556MH REG: 06/06/1
STATUS: DIS IN BED: 1 DIS: 06/06/1
HC#: 6531424239-ND DISP:

CHEMISTRY

CHEMISTRY REFERENCE LAB TEST RESULTS

	Date / Time					Reference	Units
	6 JUN 12 1910						
Ammonia	358(@a)	H				(7-35)	umol/L
Valproic Acid	661(@a)					(350-700)	umol/L

NOTES: (@a) Guelph General Hospital, 115 Delhi Street, N1E 4J4

The following shows how the ammonia levels started coming down after the Levocarnitine antidote was restarted. This proves that if it had been restarted earlier it is unlikely that Joshua would have got to the point of no return and would have continued to progress well as he was before the Levocarnitine was discontinued by Dr. N. at 10:30 that morning.

CAMBRIDGE MEMORIAL HOSPITAL **PAGE 8**

RUN DATE: 18/06/12 700 Coronation Blvd., Cambridge Ont. N1R 3G2
RUN TIME: 0736 519-621-2333 ext.2210
RUN USER: HBUI1

4A DAILY SUMMARY 5 DAY BACKUP REPORT

LOCATION
Medicine I

Patient: PATEY,JOSHUA ALVIN **Acct #**AC001671/12 **Unit #**016955 **(Continued)**
Reg Dr: S

CHEMISTRY (CONTINUED)

CHEMISTRY REFERENCE LAB TEST RESULTS

	Date	7 JUN 12				
	Time	0105	0515	0900	1445	Reference Units
>	Ammonia	**221(@a) H**	**53(@a) H**	**47(@a) H**	**78(@a) H**	(7-35) umol/L
>	Valproic Acid	**248(@a) L**	**443(@a)**	**424(@a)**	**299(@a) L**	(350-700) umol/L

	Date	7 JUN 12	8 JUN 12			
	Time	2108	0255	0915	1555	Reference Units
>	Ammonia	**79(@a) H**	**58(@a) H**		**59(@a) H**	(7-35) umol/L
>	Ammonia			**52(@b)**		(15-55) umol/L
>	Valproic Acid	**220(@a) L**	**136(@a) L**	**105(@a) L**		(350-700) umol/L

	Date	8 JUN 12	9 JUN 12	10 JUN 12		
	Time	2046	0645	0305	1100	Reference Units
>	Ammonia	**37(@a) H**	**33(@a)**	**58(@a) H**		(7-35) umol/L
>	Ammonia				**39(@c) H**	(9-33) umol/L

	Date	11 JUN 12	12 JUN 12			
	Time	1100	0650	1632		Reference Units
>	Ammonia	**23(@a)**		**71(@a) H**		(7-35) umol/L
>	Ammonia		**35(@b)**			(15-55) umol/L
>	Valproic Acid			**(R) L**		(350-700) umol/L

(R) < 69 L
See also (@a)

Test	Date	Time	Result	Reference	Units
> Glucose POC	12 JUN 12	1618	**12.4**		mmol/L

NOTES: (@a) Guelph General Hospital, 115 Delhi Street, N1E 4J4
(@b) HAMILTON REFERENCE CENTRE, 25 CHARLTON AVENUE EAST, HAMILTON, ONT.
(@c) Grand River Hospital, KW Health Centre, 835 King St. W, Kitchener.

> "Mr Patey had also ingested other substances, each with potential adverse effects. These were not yet seen and since the sedative effects of valproic acid (and possibly ethanol) were predominant. Given the probability that when these sedative effects waned, the effects of other drugs (including agitation, hemodynamic changes etc.)would be uncovered. Dr. N. should have chosen to transfer Mr. Patey to a medical unit. The unpredictability of what might happen made the Mental Health unit an inappropriate transfer point."
>
> "We do wish to make clear, however, that while the transfer to the Mental Health unit was not the best decision, the final outcome was not, in our view, impacted. Dr. S. became involved in Mr. Patey's care before any potential negative consequences related to the transfer occurred, and subsequent events were not related to Mr. Patey's location. Later developments (agitation, intubation, etc) would likely have occurred regardless of transfer of care. We note the IO provider has opined that the sudden change in status was a new development and not compatible with progression of ammonia levels."

The college did agree with me that Dr N. should not have medically cleared Josh and sent him to the Mental Health unit, giving Dr. N. a "letter of caution". However they claim it had nothing to do with what happened next. Let me tell you it had everything to do with what happened next.

Now the same psychiatrist, Dr. G., who knew full well about Josh's rising blood ammonia levels accepted Joshua to the mental health floor. I want to make it very clear that the mental health floor does not deal with any physical medical issues and are not equipped to handle such things like IV's. Therefore this is just like sending you home.

Even the nurse on the mental health unit questioned this.

SEE FOLLOWING RECORD

	Date	Time	By	Nurse Type	
Occurred:	06/06/12	2011	SXS S	RN	Category
Recorded:	06/06/12	2017	SXS S	RN	Nursing Notes

Abnormal? N **Confidential?** N

PRIOR TO ADMISSION WRITER REVIEWED PT'S CURRENT BLOOD WORK WHICH WAS DRAWN IN ER. WRITER CALLED DR G TO QUESTION IF HE WAS AWARE OF PT'S CURRENT LAB AMMONIA 100 AND INCREASED VALPROIC ACID LEVEL, AS THIS IS ? MED CLEAR. DR STATES HE WAS AWARE AND THAT THE ER DR HAD MEDICALLY CLEARED HIM.

Note Type	Description
No Type	NONE

At 6:00 pm poison control contacted the hospital because they had not heard from them for some hours. They were very concerned about his mental and physical state when they heard of his rising levels. Dr. G., the psychiatrist, then contacted Dr. N. who had medically cleared Josh and I quote again what is in the records " he stands by his decision - patient is medically cleared despite poison controls concerns and suggestions." How arrogant is this?

SEE RECORD BELOW

RUN DATE: 18/06/12 Cambridge Memorial ** Patient Care ** PAGE 1
RUN TIME: 0827 List Patient Notes
RUN USER: HBUI1

Patient: PATEY,JOSHUA ALVIN
Account #: MA000084/12 Unit #: 016955

Age/Sex: 25 M Attending: G
Location: 5BMH Admitted: 06/06/12 at 1649
Room/Bed: 556MH-1 Status: DIS IN

	Date	Time	By	Nurse Type
Occurred:	06/06/12	1800	DXH H	RPN
Recorded:	06/06/12	2041	DXH I	RPN

Category: Nursing Notes

Abnormal? N Confidential? N

Poison Control contact Kowasillia contacted the unit to inquire about pt's condition and to speak with pt's co-assign nurse. Explained nurse was doing an admission with pt. and that was ambulatory on the unit for supper but was a bit groggy. Posion control was going to sign off on case and stated if any concerns they could be called at any time. They had also asked was pt's repeat blood work (Epival and Ammonia levels were). Blood work results Ammonia - 100 and Epivan - 701 collected at 1300hrs today were given to Poison control who were very concerned about this bloodwork and the impact medically this may have on pt. Blood work from this morning at 0500 was Epival level lower than 69 and Ammonia level 18. Poison control stated that they were unaware and not called about increase in levels at 13.00 and were concerned about pt's stability. They could not say whether pt. shouold be admitted on this unit but did feel with these results pt. was a risk for decreased CNS, hypotension and decreased LOC. There reccomendations at this time were for an IV access as unpredictability of pt. acute at this time, also blood work levels to be drawn q6hrs as well as closely monitored by a nurse.
Poison control suggested following up with the DR. regarding this information.
1810 - Charge nurse informed and Shift Admin notified of above situation.
1815 - Unit manager K made aware of this situation.
Suggested a Risk Pro be filled out and Dr. G to be informed as well.
1820 - Dr. G informed of above info and the reccomendations and concerns of Poison Control. He will contact Dr. N who cleared the pt. medically.
1830 - Dr. G called back to the unit and was unable to get ahold of Dr. N but did get a hold of Dr. S (acting as INternest today). She will be in to assess pt's medical status. He explained the situation to Dr. S who will be looking into the pt's situation. Writer suggested having repeat Epival and Ammonia levels drawn now and sent out STAT. This was ordered and enetered by writer.
1835 - Dr. G called back and he was able to get ahold of Dr. N who he stated he stands behind his decision that the pt. is medically cleared despite Poison Controls suggestions and concerns. Dr. S coming in still to assess situation. Dr. G does not wish an IV start at this time.
1920 - Dr. S in to assess pt. Information provided. Suggestions from Posion control provided to Dr. S Dr. S feels pt. shold be monitored and that blood work should be repeated. She is concerned about blood work levels. Made aware that STAT levels were drawn and sent out STAT.
Dr. S asked writer to contact Poison control to find out dosing of Anecdote for Increased blood levels.
1942 - Posion control contacted. Suggestion were for baseline ecg, repeat blood work which was drawn, IV access as well as Levocarnitine dosin in case pt. needs this medication. Information obtained from Kowasillia from Poison

What he did most definitely set off the chain of events that led to Joshua being restrained chemically and physically in the ICU which most certainly caused the blood clot that killed him.

Joshua was let go for almost 12 hours without the antidote and his ammonia levels kept rising. Dr. N. claims this had nothing to do with him ending up in ICU but Josh had all the symptoms of the rising levels especially the most serious ones.

See symptoms below taken from the internet.
http://www.healthgrades.com/right-care/kidneys-and-the-urinary-system/elevated-blood-ammonia-level--symptoms

Common symptoms of elevated blood ammonia level

Symptoms of elevated blood ammonia can occur frequently, even daily, or just occasionally. At times, any of these symptoms can be severe:

Confusion
Fatigue
Loss of appetite
Nausea with or without vomiting
Pain in the back, sides or abdomen
Weakness (loss of strength)

Symptoms that might indicate a serious condition

In some cases, elevated blood ammonia can be a serious condition that should be immediately evaluated in an emergency setting. Seek immediate medical care if you, or someone you are with, have any of these serious symptoms including:

Absent or markedly decreased urine production
Change in level of consciousness or alertness, such as passing out or unresponsiveness
Changes in mood, personality or behaviour
Sudden confusion

If you look at the nurses notes you can clearly see that Josh had many of the above symptoms. First of all you will see that they could not wake him and he was unresponsive.
Then came the change in his behaviour and the confusion.

	Date	Time	By	Nurse Type
Occurred:	06/06/12	2322	SXP P	RN
Recorded:	06/06/12	2348	SXP P	RN

Category: Nursing Notes

Abnormal? N **Confidential?** N

2000-pt sleeping soundly-breathing deeply-phone report given to Charge Nurse and at her request pt to remain on 5MH for a short while due to acuity on Med
2030-pt woken for transfer-pt informed to get in a wheelchair but he did not and looked right past this writer and was mumbling incoherently-pt was confused and acting erratically-went out into the hall and started banging on the door trying to get out-security and 2 other nurses present with this writer-when pt asked what his name was he responded "over there" when asked if he knew where he was he responded "Josh" and continued to roam around erratically-at this time,more security arrived and pt was persuaded to get into the wheelchair and pt was moved to 5 Medicine-pt placed on his bed and report given to pts nurse
2200-Dr.G called Mental Health unit to enquire about pt-informed that he had been moved to 5Medicine per Dr.S orders and also informed of pts bloodwork results

Dr N. never should have medically cleared Joshua. He should have contacted poison control and restarted the antidote. When he was receiving the antidote he seemed to be progressing well. I believe if he had done this Joshua would have never ended up in ICU and developed the blood clot.

This is nothing other than wilful criminal negligence. It was not a mistake or human error. He knew exactly what he was doing.

> **CPSO Disclosure of Harm Policy**
> Who should disclose
> All physicians involved in the care or treatment of a patient have an obligation to ensure that disclosure of harm is made. The obligation may be fulfilled either by the Most Responsible Physician12 or another physician who may have more direct knowledge of or involvement in what has occurred.
> If care is provided by a team, it is acceptable for one provider to disclose on behalf of the team. However, each physician involved in the care of the patient has a responsibility to ensure that disclosure is carried out.

According to the "Disclosure of Harm" policy of the college, the doctor is supposed to let you know when harm happens. Dr. N. caused harm to my son and the other doctors knew about this yet I had to wait until my son was dead and I received his records to find this out. Had I known this at the time he was admitted in the ICU I would have had him promptly transferred to a more competent facility. They had no right to keep this from me.

Ms. T. asked me during the teleconference what I thought of the decision from the college regarding Dr. N.. I will now answer this for her.
Dr. N. believes the "letter of caution" to be unreasonable. I totally agree. This is no more than a slap on the wrist. I hold him mostly responsible for my son's death and firmly believe he should be charged with willful criminal negligence causing death. It would seem that doctors are "above the law".

Section 219 Criminal Code
Criminal negligence

> 219 (1) Every one is criminally negligent who
>
> (a) in doing anything, or
>
> (b) in omitting to do anything that it is his duty to do,
>
> shows wanton or reckless disregard for the lives or safety of other persons.
>
> Definition of duty
> (2) For the purposes of this section, duty means a duty imposed by law.
>
> R.S., c. C-34, s. 202.

Any doctor who presumes to know more than the experts at Poison Control is a danger to all patients. He violated the college's own policies as he never discussed with Joshua about the rising levels and Joshua was led to believe he was medically clear. The doctor is suppose to tell the patient everything and the patient is supposed to be aware and involved in their treatment. Also Joshua was sent to the mental health unit at CMH and not given the choice of another facility. My son did not know he had a choice.

See the following Duties: To the Patient

Excerpt taken from Consent to Medical Treatment Policy on the CPSO website.

> **Consent must be informed**
>
> Consent is not valid unless it is informed. A physician must provide a patient with information about the nature of the treatment, its expected benefits, its material risks and side effects, alternative courses of action and the likely consequences of not having the treatment. A physician should not assume that a patient has sufficient background or may not be interested in the information. Without full information, the patient does not have sufficient background to make informed health care decisions and consent may not be valid.

I still would like the answer to a hypothetical question I asked and never received an answer to.

I asked if I presented at emergency with an ammonia level of 100 and a valproic acid level of 701 would the doctor medically clear me and send me home given the fact that I had no mental health issues. I seriously doubt I would be medically cleared.