



VERDICT AT CORONER'S INQUEST

File No.: 2008:0369:0149

An Inquest was held at the Coroners Court, in the municipality of Burnaby in the Province of British Columbia, on the following dates June 1st - 10th, 2009 before Liana Wright, Presiding Coroner, into the death of ALLAN Ross Alexander, 22, Male, and the following findings were made:

Date and Time of Death: April 15, 2008, early afternoon.

Place of Death: MSA Hospital, Abbotsford, British Columbia

Medical Cause of Death

(1) Immediate Cause of Death: a) Anoxia DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Hanging DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: Accidental, Homicide, Natural, Suicide, Undetermined

The above verdict certified by the Jury on the 10th day of June AD, 2009.

LIANA WRIGHT Presiding Coroner's Printed Name

Original signed by L. Wright Presiding Coroner's Signature



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FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

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ALLAN

SURNAME

Ross Alexander

GIVEN NAMES

Pursuant to Section 38 of the Coroner's Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: The College of Physicians & Surgeons of BC

1. That specific training and/or refresher courses be provided to physicians with respect to the legal test for committal under section 22 of the Mental Health Act
2. That physicians are reminded of the importance of obtaining collateral information from family and caregivers in the assessment process of patients being certified under Section 22 of the MHA.

To: The College of Registered Nurses of BC and The College of Registered Psychiatric Nurses of BC The Minister of Health Fraser Health Authority

3. That nurses are reminded of the importance of medical-legal charting including making complete and timely entries, as well as documenting late entries in accordance with best nursing practice.
4. That all nurses, physicians and other staff be properly trained on Code Yellow policy, and the implementation of a Code Yellow.
5. All health care workers are trained and have a clear understanding that when the police deliver a patient under the MHA it is their responsibility to ensure that these patients are unable to elope or wander freely about the hospital.
6. That all members of the health care team are trained that all MHA patients are for the most part, unable to provide true and accurate information on themselves. Therefore, the team must obtain and chart relevant collateral information from the family and/or other sources.
7. That Psych patients be discussed at all ICare meetings and Shift Change meetings so that the entire medical team is made aware of these patients.
8. That collateral information regarding MHA patients be discussed and recorded in a patient's chart.

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To: Minister of Health & Fraser Health Authority

9. That the Mental Health Act be revised to allow at the Psychiatrist's discretion, family members access to information, diagnosis, and inclusion in the treatment plan.
10. That the MSA recommendations arising from the death of Ross Alexander Allen be shared with all medical facilities.
11. That Observation Levels should be standardized throughout all medical institutions and departments. These should be posted at all nursing stations especially in the Emergency Room.
12. That training with respect to the Levels of Nursing Observation be included in all orientation sessions for newly hired and existing Physicians, Nurses, Social Workers, LPN's and Care Aides.
13. That Code Yellow be activated whenever a patient detained under the Mental Health Act goes missing.
14. That Code Yellow Policy training be included in all orientation sessions for newly hired staff and inter-facility float staff (nurses, care aides, etc.).
15. That patients admitted under the Mental Health Act wear electronic monitoring bracelets restricting them to the Emergency Department. Or as an alternative in order to easily distinguish MHA patients, they be issued a brightly coloured (blue?) hospital wrist band. in addition to the regular hospital wristband.
16. That medical and nursing staff are reminded of the CTAS (Canadian Triage Assessment Scale) scoring levels and recommended wait times for triaged patients and that lengthy delays in assessment are subjected to a follow up review from a Quality Improvement perspective.
17. That site leaders at all hospitals are not routinely required to provide nursing care to patients in the ER unless all other means to call in extra nursing staff have been exhausted.
18. That an on-call nurse/bed manager be available for after hours consultation at PAH and any other hospital for BCBedline contacts that fall outside of the 'No Refusal Policy'. This will assist in ensuring that physicians contacted via BCBedline have current bed availability information to base their decisions on whether to accept or decline a patient transfer regardless of the time of day.

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19. To provide at minimum one locking quiet room at all hospital emergency departments for patients certified and requiring observation while awaiting transfer to a psychiatric unit.
20. That at all hospitals one on one constant observation be required in the Emergency Department for any patient admitted involuntarily under s. 22 of the MHA until transferred to an appropriate department or facility.
21. To ensure that there are a minimum of 2 security guards on duty on a 24 hour basis at all hospitals.
22. That copies of the hospital chart accompany all patients transferred from one hospital to another, that the charts be accessible electronically and/or faxed within twelve hours of the patient's arrival.
23. That the ER staff routinely request or obtain any old charts from medical records upon a psychiatrist patient's presentation to the ER.
24. That cutting tools such as BCAS 'super scissors' are provided for security personnel.
25. That when a patient with schizophrenia or other mental illness is admitted to the Emergency Room, every effort should be made to keep the patient in a calm, quiet environment with softer lighting.
26. That Bed census sheets and notes made by the PCC's on these sheets are kept on file so that patient transfers and the timeliness of these transfers can be tracked.
27. That a patient's family or contact person is notified as soon as possible when a patient is determined to be missing as per Code Yellow Stage One procedure.
28. That the patient's Most Responsible Physician or Psychiatrist is contacted as soon as possible when their patient is determined to be missing.
29. That documentation is maintained with respect to transfer of admitted patients from the ER to other wards, which includes patient name and time of transfer.
30. That upon admission all certified psychiatric patients be photographed and that the photograph be available for immediate distribution in the event of a Code Yellow search.

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31. That in the event of a death such as this one that hospital administration ensure appropriate follow up is undertaken with the family.
32. That a copy of the British Columbia Mental Health Act be made available and kept at all Nurse's Stations with periodic reviews in staff meetings.
33. That all staff areas be restricted by swipe card access, including staff washrooms, storage rooms and kitchen preparation areas, etc.
34. That when hospital staff is calling the police department they must maintain a courteous and professional demeanour.
35. That in the event of a MHA patient eloping, the call should be a 911 call and not a non-emergency call.
36. That due to overwhelming substance-abuse issues throughout the province and the resulting increase in substance-induced psychosis, all hospitals provide mental health facilities sufficient to support their catchment area.

In addition, due to the statistic heard in evidence that one in every ten young adolescent men are at risk for developing schizophrenia, we make the following general recommendations:

37. That every effort be made to reduce the stigma of mental illness among young adults.
38. That a process be developed for early detection of young people at risk of developing mental health issues.
39. That in the case of a missing MHA patient, the security guard obtains a photo and physical description from the ward, and where possible quickly reviews the security tapes, prior to searching for the patient.

To: RCMP 'E' Division/All Municipal Police Services:

40. That transfers between hospitals and facilities with Psychiatric Units which involve separate police agencies be predetermined to facilitate the timely transfer of the patient.
41. That persons detained under the MHA by Police Agencies be taken to facilities with appropriate psychiatric care available.



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42. That when call centre staff/complaint takers receive a call regarding missing patients, they maintain a professional and courteous demeanour.

To: Abbotsford Police

43. That lessons learned following the Ross Alexander Allen incident be shared with all police departments, particularly the priority levels assigned by communications to missing psychiatric patients.