CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court of Alberta

in the City (City, Town or Village) of Calgary (Name of City, Town, Village), in the Province of Alberta,

on the 21 day of July, 2008 (year), (and by adjournment

on the 22 and 23 day of July, 2008 (year)),

before The Honourable Barbara Lea Veldhuis, a Provincial Court Judge,

into the death of **DIANA MITSUKO YANO** (Name in Full) 44 (Age)

of Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death: August 18, 2006

Place: Peter Lougheed Centre, Calgary, Alberta

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquiries Act, Section 1(d)).

Multiple Blunt Force Injuries

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Suicidal

Circumstances under which Death occurred:

Please see attached CIRCUMSTANCES – pages 3 to 7

Recommendations for the prevention of similar deaths:

Please see attached RECOMMENDATIONS and CONCLUSION – pages 7 to 9

DATED MARCH 24, 2009

at CALGARY, Alberta.

Judge Barbara Lea Veldhuis
A Judge of the Provincial Court of Alberta

INTRODUCTION

Diana Mitsuko Yano, 44 years of age, was an inpatient on Unit # 27 (a Psychiatric Unit) of the Peter Lougheed Centre (PLC) in Calgary, Alberta at the time of her death. Ms. Yano had a lengthy and tragic history of mental health issues including past suicidal and homicidal behavior. She was also charged criminally for an assault allegedly committed on a co-patient during her stay at the PLC on August 5, 2006.

Ms. Yano was diagnosed as suffering from a Major Depressive Disorder with psychotic features over most of her adult life. She was found not criminally responsible for the deaths of her two children, committed while suffering from the disorder in 1999. She remained under outpatient care and was re-hospitalized on a number of occasions between 2000 and 2006. She was admitted to the PLC on August 3, 2006, due to depression and to reportedly hearing voices that instructed her to harm herself and others.

On August 18, 2006, at about 2:45 p.m., Ms. Yano left Unit # 27, unaccompanied, for a walk. She was observed by medical staff to be sitting quietly in the company of a co-patient in the main hospital dining room. No concerns were observed or noted. At 5:20 p.m. Psychiatric Emergency contacted Unit # 27 and advised that Ms. Yano had jumped from the third floor of a hospital parkade and she was pronounced dead shortly thereafter.

WITNESSES TESTIFYING AT THE FATALITY INQUIRY

The witnesses testifying were:

1. Jonathan Gray (Registered Nurse, Unit # 27, PLC)
2. Maryann Reuto (Casual Registered Nurse, Unit # 27, PLC)
3. Valerie Herring (Part-time Staff Nurse, Unit # 27, PLC)
4. Shannon Middlemiss (Registered Nurse)
5. Dr. Timmy Ayas (Psychiatric Resident/Physician Extender)
6. Dr. Safeer Khan (Staff Psychiatrist)
7. Dr. Liya Xie (Forensic Outpatient Psychiatrist)
8. Dr. Philip Stokes (Inpatient Psychiatrist)

9. Ruth Roper (Patient Safety and Clinic Risk Management - Calgary Health Region (CHR))
10. Heather Coburn (Social Worker)
11. Cathy Pryce (Registered Nurse/Executive Director of Mental Health/Risk Management Coordinator - CHR)

The deceased's personal friend, Max Feldman, attended the Fatality Inquiry as an interested person.

CIRCUMSTANCES LEADING UP TO DEATH

Ms. Yano was described as having a unique and tragic history. Reports forming part of Exhibit # 1 indicate Ms. Yano had a dysfunctional upbringing. At age 19 she attempted suicide for the first time. She stabilized, pursued a university education and ultimately married. She had 2 children, a daughter in 1994 and a son in 1996. In 1997 she was diagnosed with breast cancer and underwent significant treatment. On June 29, 1999, her daughter's 5th birthday, she killed both of her children while on vacation in Fairmont, British Columbia. She was immediately hospitalized and on November 10, 1999, she was found not criminally responsible by the Supreme Court of British Columbia.

Ms. Yano remained hospitalized for over a year and was under the supervision of the Board of Review. In December 2001 she received an absolute discharge from the Board of Review in British Columbia and was admitted as a voluntary patient in Alberta at the PLC under the care of Dr. William A. Weston. Dr. Xie had her first contact with Ms. Yano in the summer of 2002 when she took over certain patients from Dr. Weston upon his retirement. Dr. Xie testified as to Ms. Yano's history in more detail from the time of her involvement.

As her role involves meeting with forensic outpatients, Dr. Xie testified that she found Ms. Yano to be stable in 2002. Ms. Yano was also seeing a psychotherapist and was under medication management.

Dr. Xie said that during 2003 - 2004 Ms. Yano suffered from Major Depression for several weeks. She also experienced bone marrow problems and as a result there was

a change in medication. Ms. Yano saw Dr. Xie quarterly on an outpatient basis and attended for psychotherapy more often.

Ms. Yano continued outpatient visits with Dr. Xie in March, June, September and December 2005. She last visited Dr. Xie on April 27, 2006. At that time, Ms. Yano was not sick although she expressed many personal issues. Dr. Xie was concerned and scheduled a follow-up appointment for May 25, 2006. Ms. Yano did not show up for the appointment. Dr. Xie next saw Ms. Yano August 3, 2006 in Psychiatric Emergency.

Dr. Xie testified that she was familiar with Ms. Yano's behavior which was usually animated - either angry or happy. On August 3, 2006, Ms. Yano was described as uncommunicative and very flat. She was indecisive and displayed impaired judgment. Based on the observations and the psychiatric history, Dr. Xie certified Ms. Yano under Section 2 of the *Mental Health Act* (R.S.A. 2000, c. M-13) resulting in Ms. Yano's admission to the PLC.

On August 4, 2006, Dr. Khan further assessed Ms. Yano and determined her to be severely depressed with "on and off suicidal thoughts." A second *Mental Health Act* certificate of admission removed the opportunity for Ms. Yano to leave the PLC voluntarily. Ms. Yano was placed on Unit # 25 for further assessment and came under the care of Dr. Stokes, an inpatient psychiatrist.

Dr. Stokes had some familiarity with Ms. Yano as a result of four prior inpatient stays. In September 2001 she was admitted for an "adjustment disorder" and released after a short stay. Within one day of her release she overdosed and was re-admitted to the PLC. A short time later Ms. Yano was transferred to the Forensic Psychiatric Institute in Vancouver, due to still being under the authority of the Board of Review in British Columbia.

In May 2003, Ms. Yano was again hospitalized at the PLC. This was near the anniversary of the death of her children.

In the fall of 2004, Ms. Yano voluntarily admitted herself. Her medications were adjusted and she improved rapidly. She agreed to weekend passes and was monitored.

The next admission was August 2006. Initially Ms. Yano was the subject of constant care in order to deal with safety concerns. She was subject to a high level of observation by the nurses and met with Dr. Stokes often. As a result of the assault allegation involving a co-patient on Unit # 25, Ms. Yano was placed on Unit # 27. Her August 9, 2006, court appearance was delayed due to the unavailability of suitable transportation and security. As well, her lawyer was not available on that date.

A plan was implemented and Dr. Stokes testified that Ms. Yano improved significantly by August 11, 2006. He said that **her previous admissions supported her "style" of rapid improvement** (my emphasis). Determination of suicidal ideation was largely dependent on observations by medical staff and communication with Ms. Yano. On August 14, 2006, Ms. Yano experienced a set back resulting from an interaction with another patient (unrelated to the earlier allegation), but improved within a day.

Dr. Stokes testified that discussion with Dr. Xie, the outpatient psychiatrist, was a necessary step to be taken for Ms. Yano's expected release and long-term care. Dr. Stokes said that communication about anticipated outpatient status and follow-up treatment strategies did not always occur between the inpatient and outpatient psychiatrists**,** although in the unusual circumstances of Ms. Yano this step was encouraged. It is unclear from the evidence at the Inquiry whether this liaison between the respective Doctors ever occurred.

Ms. Yano continued to improve and her observation status was relaxed slightly within the ward. By August 16 to 17, 2006, her hallucinations reportedly diminished and her mood remained positive. Dr. Stokes testified that he saw Ms. Yano on August 18, 2006, between 7:45 a.m. and 11:00 a.m. He said they discussed a discharge plan with supervised passes but given Ms. Yano's history, he wanted to proceed cautiously. The names of support persons and contact phone numbers were noted by staff on the medical file in anticipation of a supervised pass.

A chart note at 11:00 a.m. on August 18, 2006, indicated Ms. Yano attended an assessment treatment group and was doing well. At 2:45 p.m. Ms. Yano was noted to have a stable mood and appeared settled and calm. She left Unit # 27 for an unsupervised walk.

A further notation on the medical chart indicates that at 3:25 p.m. Ms. Yano was observed sitting quietly with a co-patient in the main hospital dining room. She was approached by the nurse who noted that Ms. Yano was pleasant and denied any concerns.

The next chart notation, at 5:20 p.m., indicated that Psychiatric Emergency contacted Unit #27 and advised Ms. Yano had jumped from the third floor of a parkade at the PLC. She was pronounced dead shortly thereafter.

REVIEW AND RECOMMENDATIONS

Cathy Pryce, CHR Risk Management Coordinator, testified respecting steps taken to address suicide risk assessment and other related matters. There was a cluster of suicides in 2006 in the CHR which resulted in a broad group of stakeholders joining together to review existing practices and policies with a view to implementing a comprehensive and formalized approach to risk management.

Three areas of focus were identified including Building Practices, Protection/Security Services and Data/Information Systems. Current practices were examined, proposed action plans were outlined and communication plans were implemented. A process was put in place by March of 2008 which outlined a number of recommendations. In May of 2008 the accepted recommendations resulted in the following:

1. All suspected or actual suicides of patients, visitors, physicians and staff on CHR property or facilities will be reported into the Safety Learning Reporting (SLR) system to facilitate tracking and trending.
2. Protection Services will coordinate reporting of these events into the SLR system to ensure consistency and accuracy.

3. Events gathered from the SLR system will assist in identifying suicide events where the building environment or structure contributed to, or failed to prevent, the intentional self-injury.

4. Events will be tracked and trends identified by various stakeholders and reported for review and action.

5. An analysis of the value and costs of building deterrents will be initiated by Planning & Capital Development when the structural environment contributes to, or fails to prevent intentional self-injury.

6. The review of all plans for renovations and new construction will address and acknowledge an awareness of suicide prevention.

7. Protection Services and Mental Health & Addictions Services will continue to be regular advisors and contributors at design meetings.

In early 2007, as part of the review process, and prior to the final recommendations, in excess of 800 staff were provided with information sessions and an education tool kit to deal with suicide risk assessment and documentation. Patient oversight and record keeping were emphasized with a view to minimizing risk of self-injury. A Policy and Procedure Manual outlining, among other things, consistent observation levels was developed. Emphasis was placed on document preparation and record keeping to ensure detailed tracking of patients during their stay with the CHR. Core competencies were identified for assessing and managing suicide risks. Strategies for management of patient care were developed.

CONCLUSION

1. Many areas of concern have been identified and addressed by the recommendations set out regarding improved documentation and detailed tracking of patients on mental health units.

2. As well a number of environmental risk factors have been identified, and building and renovation planning processes will mitigate safety risks where people may choose to self-harm on or around CHR facilities by jumping from buildings, parking structures or open air atriums, or through windows.

3. It is unclear whether there is a protocol in place in the CHR for follow-up practices for outpatient clients, particularly those with a forensic history like Ms. Yano, who fail to appear for follow-up appointments. Ms. Yano failed to show for a scheduled follow-up in May 2006, an irregularly scheduled appointment booked because of a psychiatrist's concern for Ms. Yano's mental health. She was left to her own devices until her admission in August 2006. Some patients may not be capable of taking personal responsibility for their mental health care. There should be a clear procedure for reaching out to patients who may be high-risk for issues such as self-harm, non-adherence to treatment plans, forensic activity, poor medication management and other areas of concern. Any follow-up steps should be documented as part of the detailed tracking procedure now in place.

4. It is also unclear whether there is a protocol in the CHR for liaison between inpatient psychiatric care and on-going outpatient psychiatric care, particularly for high-risk patients such as Ms. Yano. While the enhanced document preparation may assist while someone is an inpatient, without communication with the outpatient psychiatrist, the risk may not be managed as well, or at all. Such a protocol should be implemented if it does not exist.