

Q2007-53



Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury Verdict du jury du coroner

We the
undersigned
Nous soussigné

_____ of Essex, ONT
de

_____ of Windsor, ONT
de

_____ of Essex, ONT
de

_____ of LaSalle, ONT
de

_____ of _____
de

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille DUPONT	Given names / Prénom Lori
---	-------------------------------------

aged 36 held at **Windsor, Ontario**
 âgé(e) de qui a été menée à

from the 24 September to the 11 December 2007
 du a la

By Dr. **Andrew McCALLUM** Coroner for Ontario
 Par coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- | | |
|--|---|
| 1. Name of deceased
Nom du (de la) défunt(e) | Lori Arline Dupont |
| 2. Date and time of death
Date et heure du décès | Nov. 12, 2005, 9:27am |
| 3. Place of Death
Lieu de décès | Hotel-Dieu Grace Hospital, Windsor, Ontario |
| 4. Cause of death
Cause du décès | Bleeding due to multiple stab wounds to the chest. |
| 5. By what means
Circonstances entourant le décès | Homicide |

D

The verdict was received on the 11th day of December 2007
 Ce verdict a été reçu par moi le



 Original signed by Coroner



Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury Verdict du jury du coroner

We the
undersigned
Nous soussigné

of Essex, ONT
de _____
of Windsor, ONT
de _____
of Essex, ONT
de _____
of LaSalle, ONT
de _____
of _____
de _____

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille DANIEL	Given names / Prénom Dr. Marc
---	---

aged 50 held at **Windsor, Ontario**
âgé(e) de qui a été menée à

from the 24 September to the 11 December 2007
du a la

By Dr. **Andrew McCALLUM** Coroner for Ontario
Par coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- | | |
|--|--|
| 1. Name of deceased
Nom du (de la) défunt(e) | Marc Daniel |
| 2. Date and time of death
Date et heure du décès | Nov. 15, 2005, 3:44am |
| 3. Place of Death
Lieu de décès | London Health Sciences Centre, Victoria Campus
London, Ontario |
| 4. Cause of death
Cause du décès | Anoxic ischemic encephalopathy and
bronchopneumonia due to Midazolam toxicity |
| 5. By what means
Circonstances entourant le décès | Suicide |

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the
Ce verdict a été reçu par moi le

day of

20

Original signed by Coroner

Dupont / Daniel Inquest

OPENING STATEMENT

The jury wishes to express sincere condolences to the family of Lori Dupont and to the family of Marc Daniel. We also recognize the profound effect that this tragedy has had on the Hotel-Dieu Grace Hospital and this entire community.

Rest assured that throughout these proceedings, this jury has taken its responsibilities seriously and acted diligently with the charge of making recommendations that will hopefully save lives in the future with regards to domestic and workplace violence.

JURY RECOMMENDATIONS

TO THE LEGISLATURE OF ONTARIO and THE MINISTRY OF HEALTH AND LONG TERM CARE:

1. There should be a review, conducted on a priority basis, of the *Public Hospitals Act* (PHA) with a view to examining the hospital-physician relationship to ensure safety and quality of care in hospitals. This detailed review should involve various stakeholders, including but not limited to: the Ontario Hospital Association, the Ontario Nurses Association, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario (CPSO), and should have the goal of ensuring and promoting the safety of staff and patients as well as quality of care in Ontario's public hospitals. The following principles and considerations, raised by the evidence at this inquest, should be addressed:
2. Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superseded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.
3. Review the parameters for the approval of credentialing applications and for re-appointments to the medical staff.
4. Develop a process or mechanism for the early identification of and response to Disruptive Physician Behaviour, including timely and effective disciplinary actions.
5. Simplify the process for non-approval of re-appointment, immediate suspension or revocation of Hospital privileges and for the initiation of probationary status.
6. Following an investigation by a Hospital Board or Medical Advisory Committee regarding serious complaints, including disruptive physician behaviour, affecting quality of patient care and / or patient and staff safety, non-approval of re-appointment, immediate revocation, suspension and initiation of probation status should be implemented.
7. The current system of repetitive hearings should be eliminated and replaced by a streamlined system whereby physicians have an opportunity for an immediate hearing before an external tribunal (independent of the Hospital) following a decision by the relevant decision maker at the Hospital level. The decision following such a hearing may be appealed at the Divisional Court.
8. Make available to hospitals the services of an "ombudsman" who would have the power to receive complaints about physicians, conduct investigations, report back as appropriate, and grant remedies.
9. The requirement of mandatory reporting to the CPSO in section 33 of the PHA should be reconciled with the reporting obligation in section 85.5 of the *Regulated Health Professions Act* (RHPA) and should include reporting for physicians who have been placed on probationary status and/or have had their privileges restricted/reduced during an investigation.
10. The PHA should (either through the Act itself or through enabling Regulation governing hospital by-laws) explicitly recognize the application of the Occupational Health and Safety Act (OHSA) and the Ontario Human Rights Code (OHRC) to physicians with privileges at public hospitals when the behaviour of physicians negatively impacts on the staff of the hospital.

Rationale: Despite significant and documented complaints of serious disruptive behaviour problems and infractions of the Hospital Policies and by-laws by Dr. Daniel in the Spring of 2004, there seemed to be much confusion and indecision as to how to deal with this physician. The Public Hospitals Act should identify processes for Hospitals to proactively temporarily suspend a physician's privileges for assessment and treatment of significant issues of disruptive behaviour. Currently the Act (Chapter 40, Section 34) limits immediate suspension of privileges for serious problems related only to diagnosis, care or treatment of patients and fails to address issues of disruptive behaviour which could impact hospital staff or patient care.

TO THE ONTARIO HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL and TO THE PUBLIC HOSPITALS OF ONTARIO:

11. The Hotel-Dieu Grace Hospital and all public hospitals should conduct a review of their by-laws to ensure, to the extent that the matters below are not already addressed, that their Medical Staff Governance By-Laws and other staff policies are updated. The following principles and considerations, which have been raised by the evidence at this inquest, should be among the matters included in such a review:

12. Patient and staff safety, and quality of care must be the most important factors and not be superceded by a physician's right to practice. Hospitals should be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.

13. Adopt the approach to progressive discipline as set out in the 2006 College of Physicians and Surgeons of Ontario (CPSO) Working Document from its Disruptive Physician Behaviour Initiative.

14. Hospitals should establish clear codes of behaviour, supported by procedures that are conducive to a culture that encourages and supports early identification and intervention, meaningful discussion (including mechanisms to support complainants who are reluctant to participate in formal processes), appropriate actions and follow-through, including remedial and disciplinary action.

15. Professional staff by-laws should include expectations regarding professional behaviour and appropriate actions, including revocation or suspension of privileges, in order to address disruptive physician behaviour.

16. Professional staff by-laws should identify a probationary status for physician appointments. Probationary periods, including duration, reasons, mechanisms for monitoring and evaluation, expected outcomes and resolution should be documented. The Medical Advisory Committee (MAC) and Hospital board should approve both the probationary period and removal of probationary status.

17. The initial appointment process for physicians (including the requisite application form) should identify previous problematic behaviour or social health problems, e.g. conclusions and findings related to prior professional care or behaviour, reference concerns, criminal convictions and current legal actions or proceedings, previous voluntary or involuntary resignation during investigations, reasons for resignation from previous positions/employment/appointments, and relevant health history including drug abuse or attempted suicide.

18. The re-appointment process (including the requisite application form) should identify any concerns (as mentioned above) that have arisen since the last appointment or re-appointment date.

19. Professional staff by-laws should ensure annual evaluation of physicians' quality of medical care, utilization of resources, completion of required programmes, and professional behaviours including interactions with patients and staff. Such evaluations should include feedback/assessments from multiple members of the healthcare team (i.e. 360 degrees).

20. Professional staff by-laws should clearly specify the roles of Chiefs of Departments and the Chief of Staff, including clear expectations for the management of disruptive behaviour.

21. The chain of command should clearly be identified to all staff to facilitate any concerns that arise and their resolution.

22. Professional staff by-laws should provide, and the Chief of Staff should ensure, that the M.A.C. and the Hospital Board shall be made aware of all re-appointment applications, including those that are being held pending further investigation or are for other reasons not being processed in the usual course (such as due to probationary agreements or leaves of absence).

23. That the Chief Executive Officer of the Hospital has the right to override the Chief of Staff and/or the Medical Advisory Committee in decisions regarding a physician's privileges when the behaviour of the physician is in violation of the hospital's codes of conduct and by-laws.

24. That members of staff and their workplace representatives should be permitted to bring directly to the attention of the hospital Board of Directors unresolved complaints of workplace violence and harassment.

Rationale: Relevant behaviour issues and complaints were not identified during Dr. Daniel's re-appointment process at the hospital. There were multiple complaints from the nurses regarding Dr. Daniel's disruptive behaviour starting in 2000 which included damage to equipment, fracture of a nurse's left ring finger, verbal abuse, unprofessional behaviour in front of patients and refusal to work with a specific nurse. Medical staff by-laws should support a culture that does not tolerate physician disruptive behaviour and make it easy to address concerns and ensure timely resolution of the issues.

TO THE ONTARIO MEDICAL ASSOCIATION, DIRECTOR OF THE PHYSICIAN HEALTH PROGRAMME (PHP), THE COLLEGE OF PHYSICIANS AND SURGEONS (CPSO), THE ONTARIO HOSPITAL ASSOCIATION and to the PUBLIC HOSPITALS in ONTARIO:

The following recommendations should apply in cases of the assessment, treatment and follow-up of physicians who present with issues of mental health, and/or disruptive behaviour:

25. The PHP should have a robust assessment programme and clear guidelines for monitoring, reporting and follow-up.

26. The PHP should develop a 360-degree assessment tool to be used to determine the physician's suitability to return to work or on-call activity in cases involving mental health or disruptive behaviour issues. The tool should ensure the ability to gather relevant information from hospitals, complainants and co-workers, and other relevant parties.

27. That in any arrangements with a physician with behavioural issues that the staged approach to evaluation/assessment, management/treatment and follow-up/outcomes as identified in the taskforce report of the College of Physicians and Surgeons on Disruptive Physicians Behaviour Initiative be adopted.

28. The PHP should develop standard templates for treating clinicians, and require them to report treatment and outcomes back to the PHP.

29. The PHP should ensure that workplace monitors receive clear and complete information, at the time that they agree to serve as monitors, as to the expectations upon them, including the kinds of information that they should be seeking and reporting upon. Monitors should receive copies of the member's contract with the PHP in order to augment this information.

30. Where the member's workplace is a hospital, the chief of the medical staff at the hospital and the chief of the physician's department should be included in the member's PHP contract.

31. Where a physician's return to work is conditional upon a certification from the PHP that the physician is fit to return, there should be a full case conference involving those named in the PHP contract, prior to the issuance of such a certification to the workplace. In order to ensure the effectiveness of such case conferences, strategies need to be put into place to overcome barriers to the sharing of necessary information due to privacy concerns when abuse and harassment are issues and the safety and well being of others are engaged. Regard may be had to precedents in this area within the context of domestic abuse intervention programmes and principles for mandatory referrals to employee assistance programmes.

32. An independent assessment conducted by a professional who is completely independent of the Hospital and the physician must be completed before re-integration to work.

33. Where the member is being monitored through the PHP for a mental health issue, such monitoring should include an assessment for the potential for lethal violence. Such an assessment should always be required for patients dealing with depression or a suicide attempt or the aftermath of a separation from an intimate partner. An essential element of such monitoring is regular contact with the former intimate partner and/or workplace to ensure that there has been no abuse or that, if there has been, it has truly ended. There should not be exclusive reliance upon the patient's self-report.

34. That where the behaviour of the physician has negatively impacted on staff of the hospital, the Chief Nursing Executive be consulted regarding any concerns about the reintegration of the physician into the hospital. In addition, the nursing staff should be advised in advance of the physician's return to work date.

Rationale: Marc Daniel returned to work following the assessments of the PHP and his treating clinicians. Their letters of recommendation to return to work were based only on their interviews with Marc Daniel. There was no documentation of consultation by PHP with any of the OR nurses, the Hospital administration or Lori Dupont. When abuse and / or harassment are issues and third parties have their safety and well-being threatened, there needs to be clear releases of information that let the perpetrator know that effective treatment involves accountability and comprehensive and co-ordinated treatment services. The PHP should seek information directly from individuals who are impacted by physicians in their program and not rely solely on information from the patient, in this case, a physician.

TO THE ONTARIO HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL, PUBLIC HOSPITALS IN ONTARIO AND TO THE ASSOCIATIONS LISTED (SEE SCHEDULE "A"):

35. It is recommended that all workplaces design and implement a policy to address domestic violence (also known as intimate partner violence) and abuse or harassment as it relates to the workplace. Policies must be linked to training and actual practice. The principles and considerations that should inform the review of policies in this regard include the following matters that have been raised by the evidence in this inquest:

36. Education of employees/workers/staff about the issues of domestic violence and abuse or harassment in order to help them identify an abusive relationship in which they may be involved, and about how to reach out to co-workers for assistance. The policy at each workplace should reflect an analysis of the power differentials that exist between different groups of employees/workers/staff.

37. Mediation should not be utilized for incidents of violence or abuse because of the power imbalance between the parties in these circumstances. It is even more obvious that mediation should not be utilized for repeated offences. Employers must initiate a thorough investigation when claims of misconduct in the workplace are present.

38. Training of employers and managers and, specifically within the hospital context, physician leaders, should be provided to identify signs of abuse and to respond appropriately to employees/workers/staff who are victims and to perpetrators of domestic violence.

39. All employees/physicians who are not directly involved may report a concern, but must report witnessed abusive or violent behaviour. Reports must be acted upon regardless of whether they are verbal or written. Steps taken toward incident resolution need to be communicated to appropriate workplace parties (i.e., complainant, workplace representative, JHSC, Human Resources, Occupational Health and Safety manager) in a timely manner.

40. Make available a resource list of appropriate and local referral agencies.

41. Formulate an organized response to direct threats of domestic violence, abuse, harassment, or other legitimate complaints that occur in the workplace.

42. Develop and implement a safety plan for the victim to ensure that a number of safety/security measures are in place for protection. Staff scheduling and work re-assignments and transfers should be accommodated in situations involving a component of domestic and/or workplace violence.

43. For repeat offences, an independent review by a professional experienced in the particular area of concern (eg. persons knowledgeable in the area of domestic violence or harassment), and external to the organization, is required. Workplace managers/persons in authority in such environments should enforce sanctions and consequences, especially in the case of repeated acts of such misconduct. Furthermore, these sanctions and consequences must be monitored and follow-up conducted to ensure that they are carried out effectively.

Rationale: It seemed like several people approached their supervisors or talked amongst themselves at the hospital regarding Lori's situation, as well as other incidents of Marc Daniel's abuse and harassment. However, it seems that several people were uncertain how to go about filing a complaint or addressing the situation effectively within the realms of the workplace code of conduct. A workplace needs to outline and identify the steps that need to be taken when dealing with domestic violence situations. Even with a good policy in place, without proper training it can't be implemented. It is important that the general public and professionals understand the dynamics of domestic abuse so that the signs can be recognized and concerns can be taken seriously.

TO THE MINISTRY OF HEALTH AND LONG TERM CARE, THE PUBLIC HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL, and the PUBLIC HOSPITALS OF ONTARIO:

44. It is recommended that Hospitals have available the services of a "diversity officer", reporting to the Hospital Administrator, who is available to consult with and provide supportive assistance to complainants and potential complainants in relation to violence, abuse and harassment on the part of co-workers, including physicians. The Ministry of Health and Long Term Care should consider and implement funding options for such positions, such as through the mechanisms of the Local Health Integration Networks (LHINs).

Rationale: According to evidence of various members of hospital nursing and administrative staff, it was beneficial to have an unbiased resource person available to present concerns in the workplace.

TO THE ONTARIO WOMEN'S DIRECTORATE, THE HOTEL-DIEU GRACE HOSPITAL, And THE PUBLIC HOSPITALS OF ONTARIO, And to THE ASSOCIATIONS LISTED (see schedule A), and to THE ONTARIO MINISTRY OF LABOUR

45. There is a continuing need to better educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and the need to take appropriate action with potential abusers, victims, and their children. In particular, this education has to include an awareness of the risk factors for potential lethality and victims' responses to abuse. The programmes have to move beyond awareness to action about helpful and safe interventions for victims and perpetrators. Model programmes such as Neighbours, Friends and Families (www.neighboursfriendsandfamilies.on.ca) may be expanded in Ontario and be more directly inclusive of the role of the workplace. Skill building interventions that engage both professionals and non-professionals in practicing what they might say and do in such circumstances should be utilized in training initiatives (e.g. interactive theatre such as "Missed Opportunities").

46. It is recommended that the Health and Safety Associations (see schedule A) through consultation with the Ontario Women's Directorate develop educational material to provide support to all workplaces to train all employees/workers/staff members about the dynamics of domestic violence, abuse and harassment as well as what to do if faced with a situation where the violence enters the workplace. Employees/workers/staff should understand that they have a responsibility to report abuse and any other information that may be useful in preventing future violence. Workplaces should be encouraged to outline in a code of conduct how incidents should be reported and to whom they should be reported. This information should include the option of contacting the police directly, and should specifically direct that such reporting of abuse ought not to be left as exclusively the responsibility of the victim.

Rationale: Dr. Daniel's depression did not appear to be viewed as a lethal risk factor for Lori Dupont. Through the evidence presented, the jury has learned that male depression can be a high risk factor for domestic homicide. There seemed to be a focus on treating and managing Marc Daniel's mood and depression without dealing with his attitudes about women, relationships and abusive behaviour.

TO THE FACULTIES OF MEDICINE AT ONTARIO UNIVERSITIES, TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (CPSO), THE COLLEGE OF NURSES, THE COLLEGE OF PSYCHOLOGISTS and to the ONTARIO PSYCHIATRIC ASSOCIATION:

47. It is recommended that all health care disciplines throughout their pre-service and ongoing professional development receive education in the dynamics of domestic violence and risk assessment and intervention strategies. This training should include an understanding of lethality factors and the use of standardized risk assessment tools to use when members are treating clients who may be victims or perpetrators of domestic violence including those who present with symptoms of depression, especially following an intimate relationship break-up and/or suicide attempt.

48. The Medical schools, The CPSO, The Ontario Psychiatric Association, The College of Psychologists, and the College of Nurses should give Continuing Professional Development credits for training in the areas of violence in the workplace, harassment, bullying and domestic violence.

Rationale: Through the evidence presented, it was stated that physicians are among those who are most probable to encounter victims of domestic violence. It is essential that they learn to identify and clearly prescribe treatment alternatives and options to victims and perpetrators.

TO THE ONTARIO MINISTRY OF LABOUR:

49. It is recommended that there be a review of the *Occupational Health and Safety Act* to examine the feasibility of including domestic violence (from someone at the workplace), abuse and harassment as factors warranting investigation and appropriate action by the Ministry of Labour when the safety and well being of an employee is at issue. Specifically, the review should consider whether safety from emotional or psychological harm, rather than merely physical harm, ought to be part of the mandate of the Ministry. In this regard, the review should be directed to include an examination of the legislation and policies in place in other comparable jurisdictions, in Canada and elsewhere.

Rationale: Evidence indicated that psychological and emotional abuse can be more easily overlooked, but has long term consequences and in some cases may affect worker productivity and efficiency. It may be helpful to create another avenue for intervention through the Occupational Health and Safety Act whereby the Ministry of Labour could intervene in similar circumstances.

TO THE ONTARIO HOSPITAL ASSOCIATION, ALL HOSPITALS AND C.P.S.O.

50. In all situations involving an allegation of drug misuse, abuse or theft of drugs, and related paraphernalia from hospitals, the hospital should be required to conduct a meaningful investigation and complete and file a report to appropriate internal and/or external authorities within 30 days of such allegations or misuse of medications, surgical and/or anesthetic agents, narcotics or other controlled substances.

51. A review of the manner in which controlled substances and their wastes are handled.

52. Information regarding significant physician behavior problems should be identified by the Hospital and reported immediately to the CPSO.

53. Recognizing that processes and structures are in place, all Hospitals must ensure that employees and physicians are treated fairly and work in a safe environment.

Rationale: The evidence presented through Ms.lovino-Hopper regarding Lori's discovery of drugs and syringes in Marc's car, the responding EMS workers' discovery of drugs and syringes at Marc's final suicide attempt, Lori's mother's evidence regarding drugs and syringes found at Marc's first suicide attempt, and head of security's discovery of 30 syringes in Dr. Daniel's locker after his death, are all events that offer probable cause to at the very least review the handling of medications in hospitals.

TO THE ATTORNEY GENERAL / CROWN ATTORNEY'S OFFICE

54. The M.A.G. should ensure that in each jurisdiction in Ontario, a protocol exists between Court Administration offices and the Crown Attorney's office which will ensure that details of each peace bond application (s. 810 application) made to the court, with a component of domestic violence, is brought to the attention of the Crown Attorney's office within one working day.

55. Every Crown Attorney's office should have in place, in consultation with the local Police Service and the Victim/Witness assistance program coordinator an effective means of notifying the victim of the time and place of all hearings or procedures related to a peace bond application or charge, the victim's right to be present and shall have in place a process to notify victims who do not attend such scheduled events as to the results of the event.

56. The M.A.G. should develop an evaluation tool to periodically evaluate the effectiveness of training and to identify training needs with respect to domestic violence. The tool should also identify the extent to which training is implemented by Crown Counsel in daily practice.

57. An easily accessible process should be developed for victims and their advocates, as well as members of the public to address concerns related to issues presented before the Crown Attorneys/Assistant Crown Attorneys in Ontario.

58. Throughout Ontario, the Attorney General should ensure that there are dedicated domestic violence courts, which focus on early intervention and vigorous prosecution. These dedicated courts should be staffed by specifically trained Domestic Violence Crown Attorneys including a Victim / Witness Assistance program coordinator on hand to assist and advocate for the victim.

59. In the alternative to dedicated Domestic Violence Courts, the M.A.G. should consider expanding the hours of operation of the Current Court system to deal with cases relating to issues of domestic violence on an expedited basis.

60. The domestic violence court should deal with all cases of domestic violence within the jurisdiction from the initial application / bail hearing to the conclusion of the case. In addition, all breaches of bail orders relating to charges of domestic violence and all breaches or conditions related to peace bonds should be dealt with swiftly, effectively and consistently within the dedicated domestic violence court rather than within the general stream of cases conducted in the criminal courts.

61. Intentional court delays by the accused and their counsel should be discouraged and not tolerated.

Rationale: While recognizing that the Crown Attorney's office has made significant changes to address the Peace Bond process and Domestic violence cases, evidence suggests that the large volume of domestic violence cases may contribute to a lengthy wait for court dates and hearings. Given the prevalence and danger of spousal / partner abuse and the inherent dangers, adopting a streamlined process would result in an early intervention approach and be beneficial to victims as well as the treatment of perpetrators.

TO THE HOTEL-DIEU GRACE HOSPITAL

62. Dr. Peter Jaffe should be asked to conduct a review and revision of the current Hotel-Dieu Grace Workplace Violence Prevention Program and Policy and the Domestic Violence Awareness Training.

63. Hotel-Dieu Grace Hospital should engage Dr. Peter Jaffe, as per his offer, to train physicians regarding the Workplace Violence Prevention Program and Policy.

64. Conduct a review of security policies or measures in situations where employees / staff are exposed to dangers in the workplace from other staff / patients or visitors. Possible considerations could be increased security staff, "lock-down" drills, specific training for security in domestic violence and workplace violence.

Rationale: As a well-respected educator specializing in Domestic Violence and workplace violence, Dr. Jaffe's vast experience, knowledge, and common sense approach would be of tremendous benefit to all.

GENERAL

65. The Chief Coroner's Office should provide a report one year following release of the jury's recommendations, publicly reporting on the status of implementation of the recommendations and reasons provided by the parties for failure to implement any of the recommendations.

Schedule "A"
List of Ontario Health and Safety Associations

- Occupational Health Clinics for Ontario Workers
- Workers Health and Safety Centre
- Farm Safety Association Incorporated
- Industrial Accident Prevention Association
- Construction Safety Association of Ontario
- Education Safety Association of Ontario
- Electrical and Utilities Safety Association
- Ontario Forestry Safe Workplace Association
- Mines and Aggregates Safety and Health Association
- Municipal Health and Safety Association
- Pulp and Paper Health and Safety Association
- Ontario Service Safety Alliance
- Transportation Health and Safety Association of Ontario
- Ontario Safety Association for Community and Health Care

Verdict Explanation

Lori Dupont and Marc Daniel Inquest

September 24 – October 18, 2007

Ciociaro Club, Windsor, ON

October 29-November 1, 2007

Hellenic Club, Windsor, ON

November 5-15, 2007

Ciociaro Club, Windsor, ON

November 19-21, 2007

Hellenic Club, Windsor, ON

November 26-29, December 3-4, 11, 2007

Ciociaro Club, Windsor, ON

I intend to give a brief synopsis of issues presented at this inquest.

I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict and recommendations of the jury and is not intended to be considered as actual evidence presented at the inquest. It is in no way intended to replace the jury's verdict.

PARTICIPANTS:

Counsel to the Coroner:

**Mr. Eric Siebenmorgen
Chief Counsel
Office of the Chief Coroner for
Ontario
26 Grenville Street
Toronto, ON M7A 2G9**

Investigating Officer:

**D/Sgt. Scott Boulton
D/Cst. Dave Maddocks
Ontario Provincial Police**

Coroner's Constable:

**Cst. Adoree Fleming
Ontario Provincial Police**

Court Reporter:

**Loretta Dekold, Ontario Court of
Justice
Windsor, ON
(519) 973-6600 ext 4102**

Parties with standing:

Represented By:

1. Family of Lori Dupont

**Mr. Greg Monforton and
Ms. Ruth Stewart
Greg Monforton and Partners
100 Ouellette Avenue, 13th Flr
Windsor, ON N9A 6T3**

2. Family of Marc Daniel

**Mr. Robert Matlack
739 Walker Road,
Windsor, ON N8Y 2N2**

3. Ontario Nurses Association

**Ms. Elizabeth McIntyre and
Ms. Janina Fogels
Callaluzzo Hayes Shilton McIntyre
& Cornish
474 Bathurst Street, Suite 300
Toronto, ON M5T 2S6**

4. Hotel Dieu Grace Hospital

**Mr. Patrick Ducharme
Ducharme Fox LLP
800 University West Ave.
Windsor, ON N9A 5R9**

5. Crown Attorney's Office of Windsor

**Mr. Troy Harrison and
Mr. John Zarudny
Ministry of the Attorney General
720 Bay Street, 8th floor
Toronto, ON M5G 2K1**

6. Ministry of Labour

**Mr. Bruce Arnott
Ministry of Labour
400 University Avenue, 7th Floor
Toronto, ON M7A 1T7**

7. Drs. Burke, Taylor and Arya

**Ms. Jennifer McKendry and
Ms. Lisa Bonin
McCarthy Tétrault LLP
Box 48, Suite 4700, Toronto
Dominion Bank Tower
Toronto, ON M5K 1E6**

8. Ontario Hospital Association

**Mr. John Morris and
Ms. Nyranne Martin
Borden Ladner Gervais LLP
Scotia Plaza
40 King Street West
Toronto, Ontario, Canada
M5H 3Y4**

9. Ms. Tammy Fryer-Dougan

**Mr. Dan Scott
380 Ouellette Ave
Suite 302
Windsor, ON N9A 6X5**

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

The jury heard the testimony of fifty-one witnesses over the course of the inquest. There were one hundred and seventy six exhibits entered in evidence. There were 34 days of testimony, one day of submissions by counsel, one day for the coroner to charge the jury and a final day for the jury to deliver their verdict.

Evidence was heard that Lori Dupont, a recovery room nurse at Hotel Dieu Grace Hospital (HDGH) in Windsor, and Marc Daniel, an anesthesiologist at the same hospital, were involved in an intimate relationship that had begun sometime in 2004, after Dr. Daniel separated from his wife. Several witnesses indicated that Dr. Daniel pursued Ms. Dupont and pressed her first to have a relationship with him, and then to allow him to move into the house that Ms. Dupont had purchased for herself and her daughter. He provided funds to finance the largest portion of the purchase price.

Various witnesses testified that Dr. Daniel was involved in various disputes and altercations at work before and during this time. He had verbal disputes with co-workers and with the nurse manager of the operating room and recovery room. A nurse's finger was broken when he wrestled a pillow out of her hands (pillows were apparently viewed by him as essential equipment for inducing anesthesia). A nurse had made a written complaint after Dr. Daniel excluded her from the operating room he was working in, but this case had not been resolved by the time of the deaths some sixteen months later. The nurse manager had filed a written complaint

regarding abusive language directed at her by Dr. Daniel. This had resulted in Dr. Daniel being investigated by the hospital. After negotiation with Dr. Daniel and his counsel, Dr. Daniel signed a Memorandum of Agreement whereby he was placed on probation in January 2005, agreed to abide by the hospital's Code of Conduct and workplace harassment policy, and was required to undergo anger management therapy.

On February 27, 2005 Dr. Daniel attempted suicide using intravenous drugs commonly used to induce anesthesia. He did this in the presence of Lori Dupont, and a statement of Lori Dupont's filed as an exhibit contained information that he told her that she had "done this to him". Several witnesses testified that Dr. Daniel had previously and repeatedly used the threat of suicide to control Ms. Dupont. Ms. Dupont and her mother performed CPR on Dr. Daniel, and he was transported to HDGH where he was admitted and treated. He was initially in the ICU and then involuntarily admitted to the acute psychiatric ward. Nurses and the physicians who treated Dr. Daniel testified that he told them that pressures at work had led to his suicide attempt. However, both Lori Dupont and her mother were recorded as having called the unit to advise the staff that Dr. Daniel was not telling the truth about the reason behind the suicide attempt and that, in fact, he made the attempt to try to control Ms. Dupont who was not following his wishes that she not leave the house to go shopping. Further, Ms. Dupont's mother advised that she feared for her granddaughter's and daughter's physical safety. Barbara Dupont spoke with Dr. Daniel and informed him that he would not be allowed to contact her daughter in the future. Ms. Dupont informed Dr. Daniel that the relationship was over at that point.

On March 10, 2005, Dr. Daniel was discharged from the HDGH's psychiatric ward. His care was transferred at his request from the initial treating psychiatrist to another psychiatrist. He also began psychotherapy with a psychologist. This psychologist was the only witness who testified that she viewed Dr. Daniel's suicide attempt as an aggressive act.

During the initial days after discharge, Dr. Daniel repeatedly attempted to contact Lori Dupont. Witnesses stated that he was observed attending in the operating room and recovery room area, even though he was on medical leave and that he appeared to be watching Ms. Dupont. Ms. Dupont's parents interceded to prevent him contacting her. On or about April 5, 2005, Dr. Daniel placed a potentially embarrassing photograph of Ms. Dupont on her windshield according to witnesses. Apparently, no other person in the workplace viewed this photograph, but its contents were sufficiently embarrassing to Ms. Dupont that she was upset by his threat to distribute it. Dr. Daniel also met with Ms. Dupont's father at his place of work and made a further threat to distribute the picture unless all funds he stated were owed (from the house purchase) to him were returned. On April 8, 2005, Ms. Dupont attended a meeting of security, supervisory and legal personnel at the hospital at their request to discuss what action ought to be taken in light of this act by Dr. Daniel. Witnesses testified that Ms. Dupont was a very private person who simply wanted Dr. Daniel to leave her alone so that she could continue without him.

As a result of that meeting, Ms. Dupont sought a peace bond, but this was repeatedly delayed, and in fact, the final hearing was not scheduled until some weeks after her death. The hospital cancelled his security card access and asked him to get his psychotherapy and pick up his mail elsewhere, which he agreed through his counsel to do.

During this period, the Physicians Health Program (PHP) of the Ontario Medical Association became involved after Ms. Dupont and a colleague of Dr. Daniel notified them. The Physicians Health Program provided a contract for Dr. Daniel specifying certain information could be shared with workplace monitors and his psychiatrist, among others. However, his psychiatrist did not receive information from the workplace, and he testified that he was not aware of the extent of Dr. Daniel's behaviour in the workplace. Further, it appeared that Dr. Daniel notified the psychiatrist of his readiness to return to work, and that the psychiatrist then wrote to the Physicians Health Program, which in turn accepted that Dr. Daniel was ready to work. The hospital was notified of this by the PHP, and Dr. Daniel returned to work without the input of nursing staff and Ms. Dupont. The treating psychiatrist and psychologist testified that they were bound to respect Dr. Daniel's confidentiality and therefore could not seek corroborating or independent information on his progress or accept unsolicited information as they said that to do so would acknowledge that they were treating Dr. Daniel, which would itself be a breach of confidentiality. The jury heard a repeated theme from the mental health professionals that the bounds of confidentiality prevented them from getting a 360-degree assessment of Dr. Daniel.

Dr. Daniel returned to work at the beginning of June and almost immediately there began to be incidents of problematic behaviour on his part. Evidence was heard that he kissed a nurse on the cheek and offered to rub the naked back of another nurse. Further, staff began to be concerned about his staring at Lori Dupont in the Recovery Room when he brought patients there after cases. Witnesses testified that other nursing staff would band around the bed when Ms. Dupont received a patient from Dr. Daniel in order to shield her from his intense stares. Staff became concerned that he would "go postal". He continued to have a dispute with the nurse who had been excluded from his operating room and also with the nurse manager. He would go to the nurses' lunchroom and stare at Ms. Dupont. One witness testified that he "body checked" Ms. Dupont as they passed each other in the hallway one day.

Ms. Dupont apparently met with the nurse manager in the area but the nurse manager testified that Ms. Dupont told her that she was handling the situation. This witness again referred to Ms. Dupont's desire for privacy. Further, a number of witnesses testified that Ms. Dupont was urged by hospital management to make a written complaint, which she did not do, perhaps due to embarrassment. These witnesses stated that they believed the hospital would not act without a written complaint about Dr. Daniel's harassment.

During the period before and after Dr. Daniel's return to work, there was a financial dispute between Ms. Dupont and Dr. Daniel over the funds that he had provided

towards the purchase of a house. Ms. Dupont had returned the funds but retained a percentage thereof because of the hardship she and her family believed she had endured as a consequence of Dr. Daniel's behaviour.

The jury also heard testimony from two sisters who were friends of Lori Dupont. One of the sisters worked at HDGH and in early June 2005 she approached the hospital risk manager who is also a lawyer to express her and her sister's concern for the way in which Dr. Daniel had returned to work and the effect that his behaviour had on Ms. Dupont. She testified that the risk manager had said that it was difficult to remove a doctor's privileges. The risk manager disputed this version in her testimony, stating that she had not read the detailed email sent by the sister, nor did she know the full extent of the concerns.

A number of hospital witnesses were asked why Dr. Daniel's contraventions of the Memorandum of Agreement after his return to work in June 2005 did not lead to further action on the part of the hospital. The hospital's Chief of Staff testified that he viewed Dr. Daniel as ill and the behaviour as a symptom of his illness, and he thus wanted treatment for Dr. Daniel as opposed to discipline. No other explanation was offered by any other witness.

The case manager for the Physicians Health Program testified that the week prior to the deaths, Dr. Daniel met with her and spoke obsessively about Ms. Dupont. This concerned her and she asked the psychologist to reassess Dr. Daniel. Unfortunately, the deaths occurred before this could be done.

A number of witnesses were questioned about what action they had taken regarding Dr. Daniel's behaviour after February 2005. No evidence was given that any official from the hospital or elsewhere confronted Dr. Daniel concerning his behaviour toward Ms. Dupont. Aside from a request by Ms. Dupont's father that the Amherstburg police increase their patrols by her house, no person contacted a police agency about his behaviour toward Ms. Dupont.

On Saturday, November 12, 2005, Lori Dupont and Marc Daniel were scheduled to work together. At about 9:00 am, Ms. Dupont was in the Recovery Room getting equipment ready for the day. Dr. Daniel came into the room and spoke with a co-worker of Ms. Dupont. The co-worker turned away and then heard screams. She turned back and observed Dr. Daniel stabbing Ms. Dupont. Dr. Daniel then exited the hospital, and was observed on surveillance video leaving the hospital in his car. Despite a heroic resuscitation attempt by the operating and recovery room staff, which included a cardiothoracic surgeon, Ms. Dupont could not be resuscitated.

Dr. Daniel called his wife on his cellular phone and told her he had killed Ms. Dupont. He told his wife that he was going to kill himself. His vehicle was tracked to the Windsor waterfront. The Windsor police approached the car using a tactical approach due to the unknown danger presented by Dr. Daniel. When they got close to the car, they observed Dr. Daniel unresponsive (he was, in fact, vital signs absent)

in the car. He was aggressively resuscitated by paramedics and had a return of vital signs. However, he died three days later in the ICU at London Health Sciences Centre.

The jury heard the testimony of three expert witnesses. The first two, a physician who is a senior executive in an Ontario hospital and a lawyer who specializes in physician privilege issues provided an expert report and also testified as a panel. These experts testified that the current legislation governing physicians' privileges in Ontario hospitals, the Public Hospitals Act, could be simplified with the benefit of allowing hospitals to deal with problematic physicians more expeditiously. Based on the principle that justice delayed is justice denied, physicians would also benefit because formerly lengthy proceedings requiring a hearing before the Medical Advisory Committee, the hospital Board and potentially the Health Professionals Appeal and Review Board would be truncated. These experts recommended adopting a simpler format for dealing with physician privilege issues. They recommended that once a decision has been made by the hospital to limit, alter, suspend or revoke a physician's hospital privileges, any appeal should be made directly to an external tribunal specifically formed to deal independently with privilege matters.

The senior executive physician recommended the adoption of the Disruptive Physician Behaviour Initiative approach of the College of Physicians and Surgeons of Ontario as a means of dealing with a disruptive physician, along with enforcement of a code of conduct, and addressing behavioural issues during the initial application process and at the annual re-application process. He further recommended that probationary status for physicians be defined in hospital By-Laws, which should define the specific roles and responsibilities of the Chief of the Medical Staff and medical Department Chiefs with respect to dealing with disruptive physicians. Further, he recommended extensive changes to the Public Hospitals Act to allow early identification and management of disruptive physicians, as well as a requirement for a probationary status for physicians. He recommended that suspension of an alleged seriously disruptive physician's hospital privileges should continue until the ultimate hearing. He recommended that the Physician Health Program have a standard template for reporting to them on physicians that they are monitoring, and that the PHP do a 360 degree evaluation prior to a physician's return to work.

This witness also gave testimony in which he stated that the "picture incident" in April 2005 was a "sentinel event". He testified that a similar incident should result in definitive action to ensure the safety of staff and the competence of the physician. He also stated that it was his view as both a senior executive physician and an anesthesiologist that a hospital should fully investigate when drugs potentially taken from the hospital are misused, as was the case with Dr. Daniel's February 2005 suicide attempt.

The final expert witness was an expert in domestic violence. His comprehensive expert report was provided to the jury as an exhibit. He testified that a worker who is off work due to behavioural or mental issues should not be allowed to return to work until a full assessment of fitness to return is done. This assessment, he testified, should include seeking the consent of the worker at the outset of therapy to obtain information about the worker from peers, subordinates and supervisors at work as well as from the worker. In this case, the evidence was that the only information that the therapists had about Dr. Daniel and his state of mind at the time he returned to work was from Dr. Daniel himself. After Dr. Daniel had been back at work, there was virtually no information about his increasingly problematic behaviours given to the PHP or his therapists until several days before the deaths.

The domestic violence expert also testified that there are a number of factors associated with the risk of lethal domestic violence. In hindsight, Dr. Daniel exhibited the majority of these, most notably, clinical depression, suicide attempt and recent separation from his domestic partner. This expert testified that it is important to put boundaries on the behaviour of individuals such as Dr. Daniel, and that there must be consequences to the repeated violation of agreements such as the one signed by Dr. Daniel and the hospital. Also, the expert testified under cross examination that assessment of the potential for violence and the fitness of the client to return to work is intrinsic to treatment, and cannot be artificially separated. Finally, in response to a question from the jury, he testified that for a patient to be treated for significant mental health issues at his own hospital might represent a conflict of interest; he stated that it would be better for the treatment to be undertaken by a third-party institution and therapist.

In the opinion of this expert, victims of domestic abuse such as Ms. Dupont are often reticent to complain. The expert testified that employers and others must be sensitive to this reticence and not place the onus on the victim to pursue the perpetrator. He stated that investigation of abuse and verbal harassment should be added to the current Ministry of Labour role to investigate workplace violence. Mediation, such as was attempted between Dr. Daniel and the nurse with whom he had a dispute, should not be used where there is a significant power imbalance.

This expert was questioned about the effect of mental illness on Dr. Daniel's behaviour. He testified that even if the problematic behaviour of a person was due to mental illness, the behaviour itself could not be allowed to harm other individuals. He also testified that if a person were incompetent due to a mental disorder and harming either himself or others, then the Mental Health Act would come into play. However, he made the point that a mentally ill person may be competent and thus responsible for his or her actions, including harming, harassing or threatening others.

Verdict:

1.	Name of deceased Nom du (de la) défunt(e)	<i>Lori Arline Dupont</i>
2.	Date and time of death Date et heure she he du décès	<i>Nov. 12, 2005, 9:27am</i>
3.	Place of Death Lieu de décès	<i>Hotel-Dieu Grace Hospital, Windsor, Ontario</i>
4.	Cause of death Cause du décès	<i>Bleeding due to multiple stab wounds to the chest.</i>
5.	By what means	<i>Homicide</i>

1.	Name of deceased Nom du (de la) défunt(e)	<i>Marc Daniel</i>
2.	Date and time of death Date et heure du décès	<i>Nov. 15, 2005, 3:44am</i>
3.	Place of Death Lieu de décès	<i>London Health Sciences Centre, Victoria Campus London, Ontario</i>
4.	Cause of death Cause du décès	<i>Anoxic ischemic encephalopathy and bronchopneumonia due to Midazolam toxicity</i>
5.	By what means	<i>Suicide</i>

Dupont / Daniel Inquest

OPENING STATEMENT

The jury wishes to express sincere condolences to the family of Lori Dupont and to the family of Marc Daniel. We also recognize the profound effect that this tragedy has had on the Hotel-Dieu Grace Hospital and this entire community.

Rest assured that throughout these proceedings, this jury has taken its' responsibilities seriously and acted diligently with the charge of making recommendations that will hopefully save lives in the future with regards to domestic and workplace violence.

JURY RECOMMENDATIONS

TO THE LEGISLATURE OF ONTARIO and THE MINISTRY OF HEALTH AND LONG TERM CARE:

1. There should be a review, conducted on a priority basis, of the *Public Hospitals Act* (PHA) with a view to examining the hospital-physician relationship to ensure safety and quality of care in hospitals. This detailed review should involve various stakeholders, including but not limited to: the Ontario Hospital Association, the Ontario Nurses Association, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario (CPSO), and should have the goal of ensuring and promoting the safety of staff and patients as well as quality of care in Ontario's public hospitals. The following principles and considerations, raised by the evidence at this inquest, should be addressed:
2. Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superceded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.
3. Review the parameters for the approval of credentialing applications and for re-appointments to the medical staff.
4. Develop a process or mechanism for the early identification of and response to Disruptive Physician Behaviour, including timely and effective disciplinary actions.
5. Simplify the process for non-approval of re-appointment, immediate suspension or revocation of Hospital privileges and for the initiation of probationary status.
6. Following an investigation by a Hospital Board or Medical Advisory Committee regarding serious complaints, including disruptive physician behaviour, affecting quality of patient care and / or patient and staff safety, non-approval of re-appointment, immediate revocation, suspension and initiation of probation status should be implemented.
7. The current system of repetitive hearings should be eliminated and replaced by a streamlined system whereby physicians have an opportunity for an immediate hearing before an external tribunal (independent of the Hospital) following a decision by the relevant decision maker at the Hospital level. The decision following such a hearing may be appealed at the Divisional Court.

8. Make available to hospitals the services of an “ombudsman” who would have the power to receive complaints about physicians, conduct investigations, report back as appropriate, and grant remedies.
9. The requirement of mandatory reporting to the CPSO in section 33 of the PHA should be reconciled with the reporting obligation in section 85.5 of the *Regulated Health Professions Act* (RHPA) and should include reporting for physicians who have been placed on probationary status and/or have had their privileges restricted/reduced during an investigation.
10. The PHA should (either through the Act itself or through enabling Regulation governing hospital by-laws) explicitly recognize the application of the Occupational Health and Safety Act (OHSA) and the Ontario Human Rights Code (OHRC) to physicians with privileges at public hospitals when the behaviour of physicians negatively impacts on the staff of the hospital.

Rationale: Despite significant and documented complaints of serious disruptive behaviour problems and infractions of the Hospital Policies and by-laws by Dr. Daniel in the Spring of 2004, there seemed to be much confusion and indecision as to how to deal with this physician. The Public Hospitals Act should identify processes for Hospitals to proactively temporarily suspend a physician’s privileges for assessment and treatment of significant issues of disruptive behaviour. Currently the Act (Chapter 40, Section 34) limits immediate suspension of privileges for serious problems related only to diagnosis, care or treatment of patients and fails to address issues of disruptive behaviour which could impact hospital staff or patient care.

Coroner’s Explanation: The jury is responding to the evidence of several witnesses from the hospital and the two experts in health care administration and law. Their rationale is clear.

THE ONTARIO HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL and TO THE PUBLIC HOSPITALS OF ONTARIO:

11. The Hotel-Dieu Grace Hospital and all public hospitals should conduct a review of their by-laws to ensure, to the extent that the matters below are not already addressed, that their Medical Staff Governance By-Laws and other staff policies are updated. The following principles and considerations, which have been raised by the evidence at this inquest, should be among the matters included in such a review:
12. Patient and staff safety, and quality of care must be the most important factors and not be superceded by a physician’s right to practice. Hospitals should be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.

13. Adopt the approach to progressive discipline as set out in the 2006 College of Physicians and Surgeons of Ontario (CPSO) Working Document from its Disruptive Physician Behaviour Initiative.
14. Hospitals should establish clear codes of behaviour, supported by procedures that are conducive to a culture that encourages and supports early identification and intervention, meaningful discussion (including mechanisms to support complainants who are reluctant to participate in formal processes), appropriate actions and follow-through, including remedial and disciplinary action.
15. Professional staff by-laws should include expectations regarding professional behaviour and appropriate actions, including revocation or suspension of privileges, in order to address disruptive physician behaviour.
16. Professional staff by-laws should identify a probationary status for physician appointments. Probationary periods, including duration, reasons, mechanisms for monitoring and evaluation, expected outcomes and resolution should be documented. The Medical Advisory Committee (MAC) and Hospital board should approve both the probationary period and removal of probationary status.
17. The initial appointment process for physicians (including the requisite application form) should identify previous problematic behaviour or social health problems, e.g. conclusions and findings related to prior professional care or behaviour, reference concerns, criminal convictions and current legal actions or proceedings, previous voluntary or involuntary resignation during investigations, reasons for resignation from previous positions/employment/appointments, and relevant health history including drug abuse or attempted suicide.
18. The re-appointment process (including the requisite application form) should identify any concerns (as mentioned above) that have arisen since the last appointment or re-appointment date.
19. Professional staff by-laws should ensure annual evaluation of physicians' quality of medical care, utilization of resources, completion of required programmes, and professional behaviours including interactions with patients and staff. Such evaluations should include feedback/assessments from multiple members of the healthcare team (i.e. 360 degrees).
20. Professional staff by-laws should clearly specify the roles of Chiefs of Departments and the Chief of Staff, including clear expectations for the management of disruptive behaviour.

21. The chain of command should clearly be identified to all staff to facilitate any concerns that arise and their resolution.
22. Professional staff by-laws should provide, and the Chief of Staff should ensure, that the M.A.C. and the Hospital Board shall be made aware of all re-appointment applications, including those that are being held pending further investigation or are for other reasons not being processed in the usual course (such as due to probationary agreements or leaves of absence).
23. That the Chief Executive Officer of the Hospital has the right to override the Chief of Staff and/or the Medical Advisory Committee in decisions regarding a physician's privileges when the behaviour of the physician is in violation of the hospital's codes of conduct and by-laws.
24. That members of staff and their workplace representatives should be permitted to bring directly to the attention of the hospital Board of Directors unresolved complaints of workplace violence and harassment.

Rationale: Relevant behaviour issues and complaints were not identified during Dr. Daniel's re-appointment process at the hospital. There were multiple complaints from the nurses regarding Dr. Daniel's disruptive behaviour starting in 2000 which included damage to equipment, fracture of a nurse's left ring finger, verbal abuse, unprofessional behaviour in front of patients and refusal to work with a specific nurse. Medical staff by-laws should support a culture that does not tolerate physician disruptive behaviour and make it easy to address concerns and ensure timely resolution of the issues.

Coroner's Explanation: Once again, this section is clearly explained in the jury's rationale and appears to relate to the evidence of the above-mentioned witnesses.

TO THE ONTARIO MEDICAL ASSOCIATION, DIRECTOR OF THE PHYSICIAN HEALTH PROGRAMME (PHP), THE COLLEGE OF PHYSICIANS AND SURGEONS (CPSO), THE ONTARIO HOSPITAL ASSOCIATION and to the PUBLIC HOSPITALS in ONTARIO:

The following recommendations should apply in cases of the assessment, treatment and follow-up of physicians who present with issues of mental health, and/or disruptive behaviour:

25. The PHP should have a robust assessment programme and clear guidelines for monitoring, reporting and follow-up.

26. The PHP should develop a 360-degree assessment tool to be used to determine the physician's suitability to return to work or on-call activity in cases involving mental health or disruptive behaviour issues. The tool should ensure the ability to gather relevant information from hospitals, complainants and co-workers, and other relevant parties.
27. That in any arrangements with a physician with behavioural issues that the staged approach to evaluation/assessment, management/treatment and follow-up/outcomes as identified in the taskforce report of the College of Physicians and Surgeons on Disruptive Physicians Behaviour Initiative be adopted.
28. The PHP should develop standard templates for treating clinicians, and require them to report treatment and outcomes back to the PHP.
29. The PHP should ensure that workplace monitors receive clear and complete information, at the time that they agree to serve as monitors, as to the expectations upon them, including the kinds of information that they should be seeking and reporting upon. Monitors should receive copies of the member's contract with the PHP in order to augment this information.
30. Where the member's workplace is a hospital, the chief of the medical staff at the hospital and the chief of the physician's department should be included in the member's PHP contract.
31. Where a physician's return to work is conditional upon a certification from the PHP that the physician is fit to return, there should be a full case conference involving those named in the PHP contract, prior to the issuance of such a certification to the workplace. In order to ensure the effectiveness of such case conferences, strategies need to be put into place to overcome barriers to the sharing of necessary information due to privacy concerns when abuse and harassment are issues and the safety and well being of others are engaged. Regard may be had to precedents in this area within the context of domestic abuse intervention programmes and principles for mandatory referrals to employee assistance programmes.
32. An independent assessment conducted by a professional who is completely independent of the Hospital and the physician must be completed before re-integration to work.
33. Where the member is being monitored through the PHP for a mental health issue, such monitoring should include an assessment for the potential for lethal violence. Such an assessment should always be required for patients dealing with depression or a suicide attempt or the aftermath of a separation from an intimate partner. An essential element of such monitoring is regular

contact with the former intimate partner and/or workplace to ensure that there has been no abuse or that, if there has been, it has truly ended. There should not be exclusive reliance upon the patient's self-report.

34. That where the behaviour of the physician has negatively impacted on staff of the hospital, the Chief Nursing Executive be consulted regarding any concerns about the reintegration of the physician into the hospital. In addition, the nursing staff should be advised in advance of the physician's return to work date.

Rationale: Marc Daniel returned to work following the assessments of the PHP and his treating clinicians. Their letters of recommendation to return to work were based only on their interviews with Marc Daniel. There was no documentation of consultation by PHP with any of the OR nurses, the Hospital administration or Lori Dupont. When abuse and / or harassment are issues and third parties have their safety and well-being threatened, there needs to be clear releases of information that let the perpetrator know that effective treatment involves accountability and comprehensive and co-ordinated treatment services. The PHP should seek information directly from individuals who are impacted by physicians in their program and not rely solely on information from the patient, in this case, a physician.

Coroner's Explanation: The jury heard much evidence about critical information not being exchanged between the various involved parties, and this particularly affected the decision regarding Dr. Daniel's fitness to return to work.

TO THE ONTARIO HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL, PUBLIC HOSPITALS IN ONTARIO AND TO THE ASSOCIATIONS LISTED (SEE SCHEDULE "A"):

35. It is recommended that all workplaces design and implement a policy to address domestic violence (also known as intimate partner violence) and abuse or harassment as it relates to the workplace. Policies must be linked to training and actual practice. The principles and considerations that should inform the review of policies in this regard include the following matters that have been raised by the evidence in this inquest:
36. Education of employees/workers/staff about the issues of domestic violence and abuse or harassment in order to help them identify an abusive relationship in which they may be involved, and about how to reach out to co-workers for assistance. The policy at each workplace should reflect an analysis of the power differentials that exist between different groups of employees/workers/staff.

37. Mediation should not be utilized for incidents of violence or abuse because of the power imbalance between the parties in these circumstances. It is even more obvious that mediation should not be utilized for repeated offences. Employers must initiate a thorough investigation when claims of misconduct in the workplace are present.
38. Training of employers and managers and, specifically within the hospital context, physician leaders, should be provided to identify signs of abuse and to respond appropriately to employees/workers/staff who are victims and to perpetrators of domestic violence.
39. All employees/physicians who are not directly involved may report a concern, but must report witnessed abusive or violent behaviour. Reports must be acted upon regardless of whether they are verbal or written. Steps taken toward incident resolution need to be communicated to appropriate workplace parties (i.e., complainant, workplace representative, JHSC, Human Resources, Occupational Health and Safety manager) in a timely manner.
40. Make available a resource list of appropriate and local referral agencies.
41. Formulate an organized response to direct threats of domestic violence, abuse, harassment, or other legitimate complaints that occur in the workplace.
42. Develop and implement a safety plan for the victim to ensure that a number of safety/security measures are in place for protection. Staff scheduling and work re-assignments and transfers should be accommodated in situations involving a component of domestic and/or workplace violence.
43. For repeat offences, an independent review by a professional experienced in the particular area of concern (eg. persons knowledgeable in the area of domestic violence or harassment), and external to the organization, is required. Workplace managers/persons in authority in such environments should enforce sanctions and consequences, especially in the case of repeated acts of such misconduct. Furthermore, these sanctions and consequences must be monitored and follow-up conducted to ensure that they are carried out effectively.

Rationale: It seemed like several people approached their supervisors or talked amongst themselves at the hospital regarding Lori's situation, as well as other incidents of Marc Daniel's abuse and harassment. However, it seems that several people were uncertain how to go about filing a complaint or addressing the situation effectively within the realms of the workplace code of conduct. A workplace needs to outline and identify the steps that need to be taken when dealing with domestic violence situations. Even with a good policy in place, without proper training it can't be implemented. It is important that the general public and professionals understand

the dynamics of domestic abuse so that the signs can be recognized and concerns can be taken seriously.

Coroner's Explanation: The jury here appears to have taken into account testimony from hospital witnesses, along with the evidence of the expert witness on domestic violence who advocated development of a coordinated plan in the workplace to deal with potential domestic violence.

TO THE MINISTRY OF HEALTH AND LONG TERM CARE, THE PUBLIC HOSPITAL ASSOCIATION, THE HOTEL-DIEU GRACE HOSPITAL, and the PUBLIC HOSPITALS OF ONTARIO:

44. It is recommended that Hospitals have available the services of a "diversity officer", reporting to the Hospital Administrator, who is available to consult with and provide supportive assistance to complainants and potential complainants in relation to violence, abuse and harassment on the part of co-workers, including physicians. The Ministry of Health and Long Term Care should consider and implement funding options for such positions, such as through the mechanisms of the Local Health Integrated Networks (LHINs).

Rationale: According to evidence of various members of hospital nursing and administrative staff, it was beneficial to have an unbiased resource person available to present concerns in the workplace.

Coroner's Explanation: The jury heard evidence that the hospital had originally had such a position but that the position had been eliminated. The incumbent had been viewed as a positive force in dealing with issues of discrimination and harassment and was seen to be an impartial arms-length advocate for human rights.

TO THE ONTARIO WOMEN'S DIRECTORATE, THE HOTEL-DIEU GRACE HOSPITAL, And THE PUBLIC HOSPITALS OF ONTARIO, And to THE ASSOCIATIONS LISTED (see schedule A), and to THE ONTARIO MINISTRY OF LABOUR

45. There is a continuing need to better educate both the public and professionals who come into contact with victims and perpetrators of domestic violence about the dynamics of domestic violence and the need to take appropriate action with potential abusers, victims, and their children. In particular, this education has to include an awareness of the risk factors for potential lethality and victims' responses to abuse. The programmes have to move beyond awareness to action about helpful and safe interventions for victims and perpetrators. Model programmes such as Neighbours, Friends

and Families (www.neighboursfriendsandfamilies.on.ca) may be expanded in Ontario and be more directly inclusive of the role of the workplace. Skill building interventions that engage both professionals and non-professionals in practicing what they might say and do in such circumstances should be utilized in training initiatives (e.g. interactive theatre such as “Missed Opportunities”).

46. It is recommended that the Health and Safety Associations (see schedule A) through consultation with the Ontario Women’s Directorate develop educational material to provide support to all workplaces to train all employees/workers/staff members about the dynamics of domestic violence, abuse and harassment as well as what to do if faced with a situation where the violence enters the workplace. Employees/workers/staff should understand that they have a responsibility to report abuse and any other information that may be useful in preventing future violence. Workplaces should be encouraged to outline in a code of conduct how incidents should be reported and to whom they should be reported. This information should include the option of contacting the police directly, and should specifically direct that such reporting of abuse ought not to be left as exclusively the responsibility of the victim.

Rationale: Dr. Daniel’s depression did not appear to be viewed as a lethal risk factor for Lori Dupont. Through the evidence presented, the jury has learned that male depression can be a high risk factor for domestic homicide. There seemed to be a focus on treating and managing Marc Daniel’s mood and depression without dealing with his attitudes about women, relationships and abusive behaviour.

Coroner’s Explanation: This is linked to the evidence of the expert on domestic violence that a better understanding of risk factors for lethal domestic violence, and domestic violence in general, is needed.

TO FACULTIES OF MEDICINE AT ONTARIO UNIVERSITIES, TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (CPSO), THE COLLEGE OF NURSES, THE COLLEGE OF PSYCHOLOGISTS and to the ONTARIO PSYCHIATRIC ASSOCIATION:

47. It is recommended that all health care disciplines throughout their pre-service and ongoing professional development receive education in the dynamics of domestic violence and risk assessment and intervention strategies. This training should include an understanding of lethality factors and the use of standardized risk assessment tools to use when members are treating clients who may be victims or perpetrators of domestic violence including those who present with symptoms of depression, especially following an intimate relationship break-up and/or suicide attempt.

48. The Medical schools, The CPSO, The Ontario Psychiatric Association, The College of Psychologists, and the College of Nurses should give Continuing Professional Development credits for training in the areas of violence in the workplace, harassment, bullying and domestic violence.

Rationale: Through the evidence presented, it was stated that physicians are among those who are most probable to encounter victims of domestic violence. It is essential that they learn to identify and clearly prescribe treatment alternatives and options to victims and perpetrators.

Coroner's Explanation: This is self-explanatory.

TO THE ONTARIO MINISTRY OF LABOUR:

49. It is recommended that there be a review of the *Occupational Health and Safety Act* to examine the feasibility of including domestic violence (from someone at the workplace), abuse and harassment as factors warranting investigation and appropriate action by the Ministry of Labour when the safety and well being of an employee is at issue. Specifically, the review should consider whether safety from emotional or psychological harm, rather than merely physical harm, ought to be part of the mandate of the Ministry. In this regard, the review should be directed to include an examination of the legislation and policies in place in other comparable jurisdictions, in Canada and elsewhere.

Rationale: Evidence indicated that psychological and emotional abuse can be more easily overlooked, but has long term consequences and in some cases may affect worker productivity and efficiency. It may be helpful to create another avenue for intervention through the Occupational Health and Safety Act whereby the Ministry of Labour could intervene in similar circumstances.

Coroner's Explanation: The jury appears to have accepted the recommendation of the expert witness in domestic violence that the Ministry of Labour should assume a role extending beyond actual physical violence in the workplace, and include workplace verbal or behavioural harassment in its mandate.

TO THE ONTARIO HOSPITAL ASSOCIATION, ALL HOSPITALS AND C.P.S.O.

50. In all situations involving an allegation of drug misuse, abuse or theft of drugs, and related paraphernalia from hospitals, the hospital should be required to conduct a meaningful investigation and complete and file a report to appropriate internal and/or external authorities within 30 days of such

allegations or misuse of medications, surgical and/or anesthetic agents, narcotics or other controlled substances.

51. A review of the manner in which controlled substances and their wastes are handled.
52. Information regarding significant physician behavior problems should be identified by the Hospital and reported immediately to the CPSO.
53. Recognizing that processes and structures are in place, all Hospitals must ensure that employees and physicians are treated fairly and work in a safe environment.

Rationale: The evidence presented through a friend regarding Lori's discovery of drugs and syringes in Marc's car, the responding EMS workers' discovery of drugs and syringes at Marc's final suicide attempt, Lori's mother's evidence regarding drugs and syringes found at Marc's first suicide attempt, and head of security's discovery of 30 syringes in Dr. Daniel's locker after his death, are all events that offer probable cause to at the very least review the handling of medications in hospitals.

Coroner's Explanation: This is related to the testimony of the above-mentioned witnesses and the recommendation of the senior hospital physician that misuse of potentially stolen drugs from the hospital must be fully investigated.

TO THE ATTORNEY GENERAL / CROWN ATTORNEY'S OFFICE

54. The M.A.G. should ensure that in each jurisdiction in Ontario, a protocol exists between Court Administration offices and the Crown Attorney's office which will ensure that details of each peace bond application (s. 810 application) made to the court, with a component of domestic violence, is brought to the attention of the Crown Attorney's office within one working day.
55. Every Crown Attorney's office should have in place, in consultation with the local Police Service and the Victim/Witness assistance program coordinator an effective means of notifying the victim of the time and place of all hearings or procedures related to a peace bond application or charge, the victim's right to be present and shall have in place a process to notify victims who do not attend such scheduled events as to the results of the event.
56. The M.A.G. should develop an evaluation tool to periodically evaluate the effectiveness of training and to identify training needs with respect to domestic violence. The tool should also identify the extent to which training is implemented by Crown Counsel in daily practice.

57. An easily accessible process should be developed for victims and their advocates, as well as members of the public to address concerns related to issues presented before the Crown Attorneys/Assistant Crown Attorneys in Ontario.
58. Throughout Ontario, the Attorney General should ensure that there are dedicated domestic violence courts, which focus on early intervention and vigorous prosecution. These dedicated courts should be staffed by specifically trained Domestic Violence Crown Attorneys including a Victim / Witness Assistance program co-ordinator on hand to assist and advocate for the victim.
59. In the alternative to dedicated Domestic Violence Courts, the M.A.G. should consider expanding the hours of operation of the Current Court system to deal with cases relating to issues of domestic violence on an expedited basis.
60. The domestic violence court should deal with all cases of domestic violence within the jurisdiction from the initial application / bail hearing to the conclusion of the case. In addition, all breaches of bail orders relating to charges of domestic violence and all breaches or conditions related to peace bonds should be dealt with swiftly, effectively and consistently within the dedicated domestic violence court rather than within the general stream of cases conducted in the criminal courts.
61. Intentional court delays by the accused and their counsel must be discouraged and not tolerated.

Rationale: While recognizing that the Crown Attorney's office has made significant changes to address the Peace Bond process and Domestic violence cases, evidence suggests that the large volume of domestic violence cases may contribute to a lengthy wait for court dates and hearings. Given the prevalence and danger of spousal / partner abuse and the inherent dangers, adopting a streamlined process would result in an early intervention approach and be beneficial to victims as well as the treatment of perpetrators.

Coroner's Explanation: The jury here appears to be recommending that the Ministry of the Attorney General build on its initial response to include further interventions.

TO THE HOTEL-DIEU GRACE HOSPITAL

62. Dr. Peter Jaffe should be asked to conduct a review and revision of the current Hotel-Dieu Grace Workplace Violence Prevention Program and Policy and the Domestic Violence Awareness Training.

63. Hotel-Dieu Grace Hospital should engage Dr. Peter Jaffe, as per his offer, to train physicians regarding the Workplace Violence Prevention Program and Policy.

64. Conduct a review of security policies or measures in situations where employees / staff are exposed to dangers in the workplace from other staff / patients or visitors. Possible considerations could be increased security staff, "lock-down" drills, specific training for security in domestic violence and workplace violence.

Rationale: As a well-respected educator specializing in Domestic Violence and workplace violence, Dr. Jaffe's vast experience, knowledge, and common sense approach would be of tremendous benefit to all.

Coroner's Explanation: This recommendation is derived from an offer given on the witness stand to provide training and review to the HDGH by the domestic violence expert.

GENERAL

65. The Chief Coroner's Office should provide a report one year following release of the jury's recommendations, publicly reporting on the status of implementation of the recommendations and reasons provided by the parties for failure to implement any of the recommendations.

Coroner's Explanation: This is the standard practice for the Office of the Chief Coroner pre-dating this inquest.

Closing comment

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that it is not the verdict. Likewise many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention and I will gladly correct the error.



Andrew L. McCallum, MD
Presiding Coroner

January 29, 2008