Ian A. Gillespie, MD, FRCPC, DipABPN, DipABLM
Consultant Psychiatrist - Specialist in Adult Psychiatry
PO BOX 48210, RPO UPTOWN, 3511 Blanshard Street
Victoria, BC V8Z 7H6
(250) 595-4222, Fax 1-888-353-3980, or Pager 1-800-850-0521

January 23, 2019

Private & Confidential

Sandra L. Kovacs, Lawyer
KAZLAW INJURY LAWYERS
570 Granville Street, Suite 1900
Vancouver, BC V6C 3P1

Subject: CRAWFORD, Hiroko D.; also known as Donna CRAWFORD
DOB: 1949, March 22 (Now age 69)
Your Legal file number: **22376-1**
Nature of claim: Assault, Friday, December 7, 2012. (age 63)
PHN: 9043 613 218

Dear Ms. Kovacs:

Thank you for your letter of August 11, 2018 requesting that I review documents related to the standard of care provided by Dr. Anna Nazif to the defendant Nicholas Osuteye on December 6, 2012. You have informed me that you act for the plaintiff, Donna Crawford, with regard to injuries and other losses she sustained on December 7, 2012 when she was assaulted by Mr. Osuteye.

I am aware that I have a duty to assist the court and not be an advocate for any party. I have prepared this report in conformity with my duty to the court. If I am called upon to give oral or written testimony in relation to this matter, I will give that testimony in conformity with my duty to the court.

Documents reviewed

The following documents, transcripts, and records provided by you in electronic form, were relied upon in forming this opinion:

1. [PL. 1.36] 13/DEC/2010 Providence Health Accreditation;
2. [PL. 1.35] 18/DEC/2013 Providence Health Accreditation;
3. [HL. 1.33] U of Alberta Health Centre clinical records;
4. Misericordia Community Hospital records (2012);
5. [HL 1.34] 2012 Dr. Dewart clinical records;
6. [PL 1.38] St. Paul's Hospital Chart;
7. [PL 1.43] Spreadsheets: re Bed availability;
8. [PL 1.44] St. Paul's records;
9. [PL 1.80] Undated encounter note prepared by Dr. Ko;
10. [PL 1.46] Forensic Psychiatric Hospital Fitness Assessment by J. Brink;
11. [PL 1.79] 10/JAN/2017 Alberta Review Board correspondence;
12. [PL 1.78] 09/FEB/2016 Alberta Review Board correspondence;
13. [PL 1.77] 07/APR/2015 Alberta Review Board correspondence;
14. [PL 1.76] 11/MAR/2015 Alberta Review Board correspondence;
15. [PL 1.75] 28/NOV/2013 Reasons for Disposition;
16. [PL 1.74] 28/NOV/2013 Disposition;
17. [PL 1.73] 25/NOV/2013 Petition to Review Panel w/ Note;
18. [PL 1.71] 21/OCT/2013 Agreed Statement of Facts in Criminal Proceedings;
[redacted]
20. [PL 1.67] 28/MAY/2013 Nomination of Near Relative Form
[redacted]
23. [PL 1.53] DEC/2012 – notes of Mercy Osuteye;
24. [PL 1.52] Undated – "A Brief History of Nicholas Alexander Osuteye";
25. [PL 1.51] Undated – "Some observations about Nicholas Osuteye" (brother's notes);
26. Excerpts from the 21/JUL/2015 examination for discovery transcript of Patricia Munro, representative of St. Paul's Hospital and Providence Health Care (specific questions and answers identified within);
27. Excerpts from the 25/MAY/2016 Examination for discovery transcript of Dr. Kristaleah Lindsay (specific questions and answers identified within);
28. Excerpts from the 25/MAY/2016 Examination for discovery transcript of Dr. Sebastian Ko (specific questions and answers identified within);
29. Excerpts from the 16/FEB/2018 Examination for discovery transcript of Nicholas Osuteye (specific questions and answers identified within);
30. Excerpts from the 08/FEB/2018 Examination for discovery transcript of Dr. Reza Pourvali (specific questions and answers identified within);
31. Excerpts from the 02/FEB/2018 Examination for discovery transcript of Dr. Anna Nazif (specific questions and answers identified within);
32. Excerpts from the 03/APR/2018 Examination for discovery transcript of Dr. Anna Nazif (specific questions and answers identified within); and

33. Excerpts from the 12/JUL/2018 Examination for discovery transcript of Dr. Sebastian Ko (specific questions and answers identified within).

These documents provided the **basis for the factual assumptions** on which my opinion is based. Any factual assumptions based on other sources than the documents reviewed will be separately noted.

I am the principal author of this report and responsible for its contents, which are based on the review of documents. My responsibility included personally reviewing the records, and formulating the opinions.

Qualifications

I am a duly qualified physician, licensed to practice medicine in the Province of British Columbia. I attended medical school at the University of British Columbia, earning a Doctor of Medicine Degree in 1971. Psychiatric Residency Training was at UBC (1971 to 1973) and at the Mayo Graduate School of Medicine in Rochester, Minnesota (1974 to 1976). I have practiced General Adult Psychiatry, in both hospital and office settings, in Victoria over the past 42 years, with 30 years of this since completing residency training involving regular on-call duties in the Emergency Department. I have qualified to provide expert opinion in the Courts of BC. I have both the Canadian (FRCPC, 1975) and American (Diplomate of the American Board of Psychiatry and Neurology, 1980) qualifications as a specialist in adult psychiatry.

My clinical work has included extensive experience in treating patients with Posttraumatic Stress Disorder (PTSD). I have regularly attended continuing education about the diagnosis and treatment of PTSD, including advanced courses at the American Psychiatric Association annual meetings. In addition to the practice of General Adult Psychiatry, since 1992, part of my practice has been devoted to the evaluation of individuals' driving ability when there is a question of cognitive impairment caused by traumatic brain injury or medical illness. From October 2015 until November 2017, I worked at Canadian Forces Base Esquimalt in the Mental Health Clinic. Diagnostic assessment and treatment of service members with PTSD and/or Traumatic Brain Injury (TBI), among other conditions, was a regular part of that work. On occasion, this work also involved certification (Form 4) of patients with acute psychosis with paranoid features who were deemed to be a danger to themselves or others, or at risk of mental or physical deterioration.

Additional areas of interest and experience include a long-standing interest in Health Promotion and public safety related to medical issues. This includes serving as Chair, Council of Health Promotion, Doctors of BC (2015-2018, with recent reappointment to 2021). I was an invited member of the Canadian Medical Association's Scientific Editorial Board which oversaw the publication of a new edition of the *CMA Driver's Guide: Determining Medical Fitness to Operate Motor Vehicles,* last previously published in 2005. The 8th edition was electronically published on November 21, 2012. I wrote the chapter on *Psychiatric Illness* and was co-author of a new chapter on *Traumatic Brain Injury*. I authored the revised chapter on Psychiatric Disorders for the 9th edition of the Canadian Medical Association's *Determining Medical Fitness to Operate Motor Vehicles: CMA Driver's Guide*. It was approved for publication by the Scientific Editorial Board, May 2015 and published July 2017.

Other qualification information is in the attached Curriculum Vitae.

Facts and Assumptions

1. On the morning of December 7, 2012, Ms. Crawford was walking in the 700 block of Pacific Boulevard in Vancouver, when she was randomly assaulted by Mr. Osuteye. Ms. Crawford sustained serious injuries in the assault, including a traumatic brain injury and facial fractures. The severity of this assault is documented in the AGREED STATEMENT OF FACTS, 21/0CT/2013, Court File No. 228422, Vancouver Registry.

~~2.~~ Minutes before, [redacted] Elizabeth Rizos, was also assaulted by Mr. Osuteye.

3. Mr. Osuteye, born 22/JUN/1977, was raised in Edmonton; he is of Ghanaian descent. He had, and has, a severe stutter. He was first diagnosed with Schizophrenia in or around 2008, when he was hospitalized at Grey Nuns Community Hospital in Edmonton, AB, for approximately 2.5 weeks. He had a second hospitalization in June of 2012 for approximately three weeks, at Misericordia Community Hospital in Edmonton, AB. The records will provide details of Mr. Osuteye's history of symptoms and the events leading to these hospital admissions. At the material time, Mr. Osuteye had a bachelor's degree and while he had started a Master's degree in the Department of Rural Economy at the University of Alberta, he did not complete this program because of his Schizophrenia. In the months prior to the events of December 2012, he was living with his mother, Mercy, in Edmonton and receiving social assistance. He had also engaged in some spontaneous travel as described in the records and at questions Q225-260; Q290-297; Q346-349; Q386-395; Q412-440; Q535-543; Q557-562; and Q669-673 of his examination for discovery transcript. [XFD Nicholas Osuteye – 20180216]

4. In or around November 2012, Mr. Osuteye 'moved' from Edmonton to Vancouver. He was residing in a Salvation Army shelter after arrival in Vancouver. The description of this transition is in quotes as it was a self-initiated change from stable outpatient care and housing arrangements, with unclear and/or unrealistic goals and planning by Mr. Osuteye.

5. Mr. Osuteye subsequently had some contact with Ministry social workers; he applied for a BC PHN and PWD status. On November 29, 2012, he had a meeting with caseworker Rosalie Rossi, who in her case notes expressed some concern about Mr. Osuteye filling his prescription medication as he reported being off his medications for two weeks. She followed up with shelter staff to confirm that client had dropped the prescription with them and that he had taken his daily dose. This concern was recorded in the PARIS electronic database available to treating providers at St. Paul's Hospital.

6. On or around December 5, 2012, Mr. Osuteye approached police, by use of their after-hours call button, after he was locked out of his shelter. He reported that he had been walking around since 0700, and having hallucinations. Vancouver Police (VPD) called paramedics who recorded their observations about the plaintiff, as documented in the Ambulance Service report dated 05/DEC/2012. Mr. Osuteye was taken by ambulance to St. Paul's Hospital.

7. I have not been provided with any record of VPD separately documenting their observations. This was not a case of Section (28) apprehension by a peace officer for transportation to hospital, as is available under provisions of the *Mental Health Act*.

8. Medical student Dr. R. Li assessed Mr. Osuteye in the emergency department. Her assessment is reflected in the handwritten Emergency Physician Assessment dated 6/DEC/2012. Emergency Physician Dr. Reza Pourvali's signature is also found on that same document, as is psychiatrist Dr. Nazif's signature and written note dated 6/DEC/2012 at 10:30 a.m. Dr. Pourvali completed a Form 4 MHA involuntary admission medical certificate dated 5/DEC/2012, for "risk of deterioration." Mr. Osuteye had an elevated CK value; he was given an IV. Dr. Pourvali's own comments are electronically recorded in the Emergency Discharge summary, under the heading "Care Provider Comments," up to but exclusive of the last sentence stating that, "psych cleared the patient." Dr. Pourvali went off shift in the early morning hours of 6/DEC/2012, his handover note is dated 6/DEC/2012 at 0658.

9. Dr. Anna Nazif, emergency psychiatrist, assessed Mr. Osuteye at approximately 9:30 a.m. on the morning of 6/DEC/2012. Her handwritten notes are recorded on the Psychiatric Assessment sheet and her dictated consultation report is also enclosed in the St. Paul's Hospital records. She "decertified" Mr. Osuteye following the psychiatric assessment [Q1653]. As documented in Dr. Nazif's Consultation Report, she was of the opinion that Mr. Osuteye did not merit a second Form 4 certificate at the conclusion of her examination and she made arrangements for his discharge from hospital shortly after completing the assessment interview.

10. At the time of the index event, Dr. Nazif was the Medical Director for Emergency Psychiatry at St. Paul's Hospital (SPH). This involved community liaison work in committees with representatives of the police and ambulance services [XFD Dr. Nazif – Q1377-1378].

11. Dr. Nazif did not see records pertaining to Mr. Osuteye's admission to Misericordia Community Hospital in June of 2012 until some considerable time after the clinical encounter. [XFD Dr. Nazif – 20180202, Q66-70]

12. Dr. Nazif obtained the contact information (name, address, telephone number in Edmonton) for Mr. Osuteye's mother, Mercy, and documented this in the records [XFD Dr. Nazif – Q1153].

13. Dr. Nazif was not overly concerned about the patient's elevated CK levels [XFD Dr. Nazif – 20180202, Q1219-1235; Q1451].

14. Dr. Nazif noted that Mr. Osuteye was treated in Edmonton with risperidone 3 mg daily which stabilized his condition and enabled discharge to community follow-up [XFD Dr. Nazif – 20180202, Q1254]. The patient reported a continued level of stability. His level of care was ~~just~~ being followed by a community care nurse in Edmonton [Q1258-1263].

15. Dr. Nazif documented that Mr. Osuteye was off his risperidone for several weeks, confirming recent non-adherence to treatment [XFD Dr. Nazif – Q1282-1283].

16. Dr. Nazif agreed that not providing a replacement for a missed dose of risperidone in hospital did not comply with her usual practice [Q1303-1315]. [cf. Q2254-2269]

17. It is unclear who requested past psychiatric records on Mr. Osuteye and who would be responsible for determining whether the records were supplied [XFD Dr. Nazif –Q1924].

18. Records from Grey Nuns Hospital (Edmonton) were received by telefacsimile transmission at SPH Emergency Department close to the time that Dr. Nazif examined Mr. Osuteye. The fax was unclear about whether that represented Pacific Standard Time or the Alberta time zone [XFD Dr. Nazif –1894-1906].

19. Dr. Nazif did not review any other records prior to her action to discharge Mr. Osuteye. She did not attempt to contact the patient's mother or Dr. Dewart, a psychiatrist in Edmonton who had provided treatment to Mr. Osuteye earlier the same year (about July 2012) [XFD Dr. Nazif – Q1963-1964].

20. By history in the preceding year, Mr. Osuteye was taking antipsychotic medication, risperidone in a maintenance dose of 3 mg daily by oral tablet route. No adverse effects from that medication are noted as being experienced by him. Specifically, there were no comments about undue sedation from this dose of medication.

21. There is no documentation of any discussion about treatment options such as discharge on Extended Leave, with a renewed recommendation of maintenance treatment with intramuscular long-acting (ILA) antipsychotic medication.

22. Mr. Osuteye had a prescription filled about one week PTA. He had reported taking the prescribed medication. Conflicting information said he had filled the prescription but not taken the risperidone. Dr. Reza Pourvali, emergency physician, said in the Emergency Discharge Summary (revised) that it was unclear if the patient was compliant with taking medication [P.47/58 of .pdf DC-06 St. Paul's Hospital records].

23. Dr. Nazif agreed that a history of violence during a psychotic break is a good predictor of future harm [XFD Dr. Nazif – Q1548-1561; Q1866].

24. A patient who is involuntarily detained under the *Mental Health Act* is deemed to consent to treatment [XFD Dr. Nazif – Q1639-1649; Q1851]. Dr. Nazif would be expected to know that, as it is covered in the Act. Physicians are advised that the involuntary section of Form 5 not be completed by the certifying physician.

25. St. Paul's Hospital had available inpatient psychiatric beds at the time that Dr. Nazif gave a discharge order for Mr. Osuteye. This action cancelled his Involuntary status [XFD Dr. Nazif – Q2074-2098; Q2096].

Appendix 3 to my report lists references related to: Reducing errors at times of transfer of responsibility for care of a patient. These are peer-reviewed articles I adopt and that assist me in forming my opinion about the appropriate Standard of Care and methods to reduce errors in care. However, I premise my opinion mostly on my experience as a psychiatrist practising in the Province of British Columbia, with specific experience in the emergency room setting.

Opinion

You requested my opinion regarding the standard of care provided by Dr. Anna Nazif in her assessment and decertification of Nicholas Osuteye on December 6, 2012.

Reasons for Form 4 certification and urgent Psychiatric Assessment of Mr. Osuteye were valid

As described above in the facts and assumptions section, Mr. Osuteye presented to St. Paul's Hospital Emergency Department via BC Ambulance Service late on the evening of December 6, 2012. He was a university-educated, unemployed 35-year-old, never married male of Ghanaian heritage.

He had travelled to Vancouver the prior month after he left Edmonton where he had been residing with his mother, receiving antipsychotic medication, and had qualified for disability income. He had a known history of schizophrenia since 2008 and had, in the past month, stopped taking prescribed antipsychotic medication for two weeks. On the day of admission Mr. Osuteye had been wandering about the city and hallucinating. He was in a dehydrated state and had walked for 19 hours.

As noted in the Consultation report by Dr. Nazif: "Brought in by ambulance. Had been walking around for 19 hours, and approached police, appeared to be responding to internal stimuli and had disorganized thinking and behavior. … Staff were concerned about him because of his odd thinking and his level of distractibility."

It was appropriate for VPD and/or BCAS to transport Mr. Osuteye to SPH Emergency Department for psychiatric assessment. The patient requested assistance from police and they called BCAS. Even in the absence of this request, there were probable grounds for Section 28 transportation to hospital by VPD under Section 28 of the *Mental Health Act*. [Q1663-1664]

Upon examination in hospital, Mr. Osuteye was certified as an Involuntary Admission, with a Form 4 completed by Dr. Pourvali, emergency physician, enabling 48 hours for completion of another certificate by a second physician, if the Involuntary status was to be extended.

While the decisions to certify a psychiatric patient for involuntary admission and treatment can be complex and challenging in any individual case, the *Mental Health Act* provides time for mental observation, gathering collateral information, and further psychiatric opinion where there may be any uncertainty with respect to risk of harm to the patient, to others, or risk of physical or mental deterioration. This is the purpose of the 48-hour certification. During that window of time, the patient and her/his family member(s) should be advised of the involuntary admission, the necessity of it, as well as their right to contest involuntary status.

There was no disagreement as to diagnosis, Mr. Osuteye having been diagnosed with schizophrenia since 2008, with his first psychiatric hospitalization in Edmonton in January, 2009.

Schizophrenia is a chronic mental illness affecting about 2% of the population and it is subject to periodic psychotic relapse. The discontinuation of antipsychotic medication is the most frequent precipitant for such deterioration.[1] Use of Cannabis or other non-prescribed substance are also known contributing factors to the risk of deterioration into psychotic relapse.

[1] Factors influencing relapse in the long-term course of schizophrenia. https://www.sciencedirect.com/science/article/pii/S092099649700131X

Dehydration, abnormal CK level, requiring treatment with IV fluids

The elevated creatine kinase (CK) level of 1645 U/L (then 1602, and 1825 on serial measurements) was indicative of some muscle damage, likely from the long periods of walking by Mr. Osuteye in the 24-hours prior to admission. Over-exercise can cause a condition called rhabdomyolysis. The pigment from damaged muscles can cause kidney damage, potentially even kidney failure. The risk is worsened by dehydration because of hemoconcentration (thickening of the blood).

This is an example of how this patient's physical welfare can be compromised by psychotic relapse.

Medscape eMedicine notes:
"Patients with a CK elevation in excess of 2-3 times the reference range, appropriate clinical history, and risk factors should be suspected of having rhabdomyolysis."

SPH Lab gives [Normal levels for CK are 50-260 U.L],
[260 x 3 = 780, therefore Mr. Osuteye was above the risk threshold, with rising levels]
[DC-06, page 48/58 on .pdf]

CK

1)	CK	1645	[50- 260 U/L]	06-Dec-2012 1:39
2)	CK	1602	[50- 260 U/L]	06-Dec-2012 5:00
3)	CK	1825	[50- 260 U/L]	06-Dec-2012 8:50

"Monitor creatine kinase (CK) levels to show resolution of rhabdomyolysis."

"Once they are well hydrated, patients with normal renal function, normal electrolyte levels, alkaline urine, and an isolated cause of muscle injury may be discharged and monitored as outpatients. Any diagnostic or genetic tests during inpatient stay should be communicated to primary care or outpatient specialty physicians."

"Aggressive and early hydration with isotonic sodium chloride solution is important for the prevention of pigment-associated renal failure."[2] Mr. Osuteye received this treatment.

The fact of Mr. Osuteye's abnormal CK level requiring IV rehydration is a critical fact. Without this necessary medical treatment Mr. Osuteye was at risk of serious kidney damage that could have had long-lasting consequences. His mental state was not such that he could be relied upon to return for a lab test, especially given his aversion to the possibility of involuntary admission to hospital. Rising CK levels were a concern and an indication for the patient to remain in hospital for IV or oral rehydration until the CK level was in the normal range.

It is unclear who was responsible for ordering the Urine for Drug Screen (UDS) and why this was not done [XFD Dr. Nazif, Vol. 2, 2018 April 3, Q1474-1480]. This special analysis of urine that checks for the presence of mind-altering drugs is useful in determining diagnosis, may establish the validity of history provided by the patient, and may help in knowing the likely timeline of improvement in the patient's mental status. All of these factors weigh on the decision about involuntary admission to hospital and the duration for inpatient care. It is unclear whether there were administrative protocols for nursing and medical staff regarding UDS testing, and whether any related recommendations from the August 2012 external Review Panel (of St. Paul's psychiatric emergency services) had been implemented. Errors of omission or commission in patient care often result from the lack of clear and consistent communication expectations and/or delegation of responsibilities.

[2] https://emedicine.medscape.com/article/1007814-treatment#d6

Informed consent discussions

Informed consent discussions with the patient about the proposed treatment to be provided, its likely benefits and any associated risks, and alternative treatment options are accepted and routine practice amongst emergency room psychiatrists in B.C. As knowledge about previous treatment (what worked, and what did not work, or what caused adverse effects) guides treatment choices, there is a clear need for the treating physician to obtain collateral history and past health records. In the specific case of a patient with a diagnosis of schizophrenia and possible paranoid features, collateral history from family is essential in assessing risk of suicide, or risk of violence to others. It also helps in determining the patient's level of insight and the history of adherence to treatment recommendations.

It is advisable and reasonable practice to have an informed consent discussion with the patient and family prior to discharge from involuntary status.

There is no documented informed consent discussion by physicians, including Dr. Nazif, nor indications that Dr. Nazif liaised with the patient's family prior to exercising her discretion to end his involuntary status by discharging Mr. Osuteye on December 6, 2012.

British Columbia's *Mental Health Act* provides the statutory foundation for the care of mental health patients, including the provisions for involuntary admission, documentation, rights of patients, a review process for disputed admissions, and notification of a patient's relatives. Relevant sections are included as Appendix 1 to this report.

BC's Mental Health Act in Plain Language was written and prepared by the Canadian Mental Health Association, BC Division Consumer Development Project in Kelowna, BC in 2004. April 4, 2005, British Columbia's Ministry of Health published the **Guide to the *Mental Health Act***. Excerpts from it, the current document in December 2012, are in Appendix 2 to this report.

> [9.0 DISCHARGE] "When an involuntary patient is discharged from involuntary status, the designated facility must immediately inform a near relative of the discharge using Form 17. ... Notice of the discharge may be sent to the near relative before the planned discharge date. Patients, relatives and others involved in the patient's care in the community should be included in discharge planning and informed of the discharge date. This will provide support for vulnerable persons upon discharge and is important to continuity of care."

Dr. Nazif dictated a comprehensive psychiatric consultation report on her assessment of Mr. Osuteye. She reports taking longer than usual for the interview time with the patient, accompanied by the medical student [Q56-57].

Dr. Nazif understood the value in minimizing or preventing psychotic relapse in patients diagnosed with schizophrenia [Q1355-1357], and agreed that a patient with schizophrenia generally doesn't spontaneously recover from psychosis in the absence of treatment [Q1514], but she nonetheless exercised her discretion to discharge him – despite accepting as fact that Mr. Osuteye was experiencing psychotic symptoms, as described in the Ambulance report and documentation by nursing and physician staff in the St. Paul's Emergency Department.

There were a number of red flags that should have alerted Dr. Nazif to the fact this patient was suffering a psychotic relapse, and was at risk of deterioration. He had left a stable familial and

treatment environment in Edmonton to 'move' to Vancouver, without planning, and to look for a job when it was clear he had not been employed for several years.

During the interview she also explored the differential explanations for the patient pausing in his speaking (whether this was thought blocking associated with schizophrenia vs. compensatory behaviour for the patient's stutter) and used this as a teaching point with the student. She also considered whether the patient was responding to internal stimuli, or was simply distracted by the busy emergency room. However, she took no steps to resolve these queries. It would have been reasonable to keep Mr. Osuteye under certification for a longer period and after administration of risperidone, to have more opportunity for observation, perhaps in a quieter area, such as the PICU ward where there were beds available.

In my opinion, Dr. Nazif knew or ought to have known of the risk of deterioration and unpredictable behaviour in this patient with schizophrenia and paranoid symptomatology. Patients with paranoid persecutory symptoms are notoriously guarded and not forthcoming in providing a history. This is understandable, as they may strongly believe that health care providers or police do not have their best interests in mind, as part of their own mistaken persecutory perceptions and thoughts. [Q2131-2132]

There was an apparent lack of integration of information and clear communication between those involved in Mr. Osuteye's care, and at the time of transfer of care. This seemed to be more a system problem at the SPH Emergency Department site but likely compromised clinical decision making [Q1915-1936; Q2124; Q2222-2225].

Records were available with respect to Mr. Osuteye's first January 8-21, 2009 psychiatric admission, at Grey Nuns Community Hospital in Edmonton. At that time, his brother had retrieved him from Edmonton airport when he was trying to embark on travel without clear plans and after a period during which his family had observed marked deterioration in Mr. Osuteye's mental functioning.

Dr. Nazif was also informed of Mr. Osuteye's latest hospital admission of three weeks in June of 2012 (only six months prior to the index event) at Misericordia Community Hospital in Edmonton, but she had not received the records from this recent hospital admission at the time she decided to decertify him.

There was a lack of clear delegation and follow-through in obtaining medical records from three psychiatric facilities in Alberta, and no apparent effort to obtain collateral history from Mr. Osuteye's mother when her name and contact information was clearly identified in the hospital chart. At least three reasonable options existed: for Dr. Nazif to call Mr. Osuteye's mother for collateral history even if Mr. Osuteye objected; to keep him for longer observation; and/or to speak with Dr. Dewart (it was likely during his office hours).

02/FEB/2018 XFD Dr. Anna Nazif (p. 54): Q312-314

Q And that's why we get collateral information – or why you get collateral information as a standard of practice.
A Yes.
Q Okay. And that's why the PARIS notes are accessed.
A Yes.
Q And so collateral information is also part of the process of – of assessing safety?
A Yes.

The consequence of this inaction resulting in missing critical information about this patient's assaultive behaviour in the past during a psychotic episode. Had the information regarding Mr. Osuteye's previous admission to Misericordia been available, or had Dr. Nazif obtained collateral information about the facts leading to his admission from his mother, or Dr. Dewart, she would have been informed of this patient's history of violent and threatening behavior during psychosis. An emergency room psychiatrist informed of this history of violent behavior should, at minimum, maintain the patient under the involuntary Certificate for further observation, to avoid the risk of physical or mental deterioration that might lead to another violent episode and harm to others.

Even if Dr. Nazif was not certain there were grounds to sign a second certificate requiring continued involuntary admission to hospital, Mr. Osuteye's existing 48-hour certificate would not have expired until midnight on December 7, 2018. Continued admission under the existing certificate would have permitted Dr. Nazif to order continued administration of the patient's risperidone in hospital, allowing his psychotic symptoms to lesson. In the event his symptoms persisted at the close of that 48-hour window, a second certificate and continued involuntary admission would have been indicated.

Even if Dr. Nazif's decision to discharge in these circumstances was reasonable, which it was not, her decision to do so without first ordering in-hospital administration of the patient's missed dose of risperidone was not in keeping with the standard of care, by Dr. Nazif's own admission. Dr. Nazif agreed that not providing a replacement for a missed dose of risperidone in hospital did not comply with her usual practice [Q1303-1315]. [cf. Q2254-2269]

Her subsequent explanation at the second discovery [Q1651-1669] that she exercised her discretion not to do so out of concern that Mr. Osuteye might be over-sedated in the daytime was not reasonable, particularly since this patient never complained about that side effect. On balance, it would have been reasonable to administer the risperidone, to ensure continued antipsychotic benefits.

In the documentation provided for review, I found no discernible reason for a discharge order within twelve hours of Mr. Osuteye's admission to SPH as an Involuntary psychiatric patient. [Q1628-1634]. There were available psychiatric inpatient beds, thus no concern about overcrowding of the Emergency Department that can result when there are no ward beds available. There were no psychiatric patients awaiting assessment – it was uncharacteristically quiet in terms of psychiatric patient needs – and more time was available to obtain collateral history, or other objective information to guide treatment decisions [Q2219-2221]. There was also available time to order Mr. Osuteye be administered his antipsychotic medication in-hospital, and to observe its effect on him.

<u>Extended Leave as an alternative treatment option for Mr. Osuteye:</u>

Extended Leave (as detailed in the *Mental Health* Act) can also be an excellent option for treatment of patients with recurrent psychiatric admissions for chronic mental disorders where lack of adherence to treatment has been a factor in the relapse. Extended Leave is basically an involuntary status treatment plan that extends into the community care realm and has a clearly outlined treatment protocol. If the patient is not adherent to the treatment, which may include injectable long-acting (ILA) antipsychotic medication, then they can be returned to hospital for further observation and treatment without having to meet Section 22 or Section 28 provisions.

It is a humane, effective, and safe treatment alternative for selected patients. Mr. Osuteye was such a patient. A return to his care arrangements in Alberta might also have been an option.

Alberta has similar provisions to BC's *Extended Leave* called a *Community Treatment Order*[3] and guidelines for who is eligible and what is required of the ordering physicians.

There is no indication in the documents reviewed that Dr. Nazif considered this treatment option or discussed it with Mr. Osuteye [cf. Q1627; Q1799].

Conclusion:

It would have been prudent to admit Mr. Osuteye to a psychiatric ward bed at St. Paul's Hospital for further observation of his psychotic relapse and to obtain more collateral history, if it was not immediately available. Early resumption of antipsychotic medication would have also been indicated.

Reasonable discharge planning is inclusive of family members and those providing aftercare.

Mr. Osuteye's assaultive behaviour and serious injuries to three strangers in downtown Vancouver was a rare event but Dr. Nazif's decision to discharge him from hospital was not reasonable, and failed to adequately consider the risk of mental and physical deterioration. [XFD Dr. Nazif, Vol. 2, 2018 April 3, Q 1355] asks about the *"risk of deterioration in a schizophrenic patient, what does that mean? What does that look like?"*

> A: *"That their illness is – most of us, I think, in practice in BC would say that it's an imminent risk for deterioration. That, you know within a relatively short time the patient's illness is going to get worse. You know, if it's someone who you've never met before, you can't judge that. If it's someone that you see repeatedly, often they have a similar pattern of deterioration. And you might certify someone saying, you know, they have a history of severe mental illness ... and have a history of deteriorating quickly off medications, for example."*

This is exactly the kind of information that family can provide to help determine risk when the psychiatrist has never met the patient before. Failure to obtain collateral history can have very serious consequences for the patient and others [redacted]

Limitations of this Opinion

[redacted]

The opinion expressed may change on the basis of differing factual assumptions.

If you have any questions about the content of this report, please don't hesitate to contact me.

Respectfully Submitted,

Ian A. Gillespie, MD, FRCPC, DipABPN, DipABLM

[3] https://alberta.cmha.ca/wp-content/uploads/2012/03/TheAlbertaMentalHealthAct.pdf [page 17]

Attachments:

1. Appendix 1 – Excerpts from the Mental Health Act of British Columbia
2. Appendix 2 – Excerpts from the (2005) Guide to the *Mental Health Act*
3. Appendix 3 – References related to: Reducing errors at times of transfer of responsibility for care of a patient.
4. Copy of August 11, 2018 Letter of Instruction
5. Current CV for Dr. Ian Gillespie

CURRICULUM VITAE

GILLESPIE, Ian Andrew *Date of this revision: 2017 August 30*

Office Correspondence Address: PO BOX 48210, 3511 Blanshard Street, Victoria BC V8Z 7H6

Office Phone (250) 595-4222 or, (250) 363-4442 (most Wed-Fri)
Pager: 1-(800) 850-0521 [Toll-free] via a paging operator
Office E-mail: gillespie.office@gmail.com
Office FAX: 1-(888) 353-3980 [Toll-free]

Recent and Current Occupational Positions

Private Practice	General Adult Psychiatry, Victoria, BC (closed office June 30)	1976 - 2011
Part-time consultation	Special interest in the assessment of Concussion	2012 - 2017
Part-time sessional	Youth Forensic Psychiatric Services, Victoria Clinic	2012
Part-time consultation	Special interest in ADHD Assessment & Treatment	2013 - 2017
Part-time contract	Canadian Forces Base – Esquimalt, Mental Health Clinic	2015 - 2017

Clinical Hospital Affiliations

Active Staff	Royal Jubilee Hospital (Vancouver Island Health Authority) Resigned hospital privileges 2004 December 31	1976 - 2004

Past Positions

Area Clinician	Ward 4A, Eric Martin Pavilion, Royal Jubilee Hospital (25-bed general hospital psychiatric ward)	1976 - 1980
Program Director	2B Psychiatric Day Program, Eric Martin Pavilion (Intensive Group Psychotherapy, 20 patients per group)	1980 - 1984

Education

Graduate & Degrees:	University of British Columbia – Medical School	1967 - 1971
	MD - University of British Columbia	1971
	LMCC - Medical Council of Canada	1971
	Full Registration, BC College of Physicians & Surgeons	1972
	FLEX - Federal Licensing Examination (USA)	1974
	Minnesota State Board of Medical Examiners License	1975
	FRCP(C) - Royal College of Physicians & Surgeons (Can.)	1975
	DABPN - Diplomate of the American Board of Psychiatry & Neurology	1980

Professional:	Internship - Psychiatry - Vancouver General Hospital	1971 - 1972
	Psychiatry Residency - University of British Columbia	1972 - 1974
	Psychiatry Residency - Mayo Graduate School of Medicine – Rochester, Minnesota	1974 - 1976
	Physician Leadership Program (Certificate) - Sauder School of Business, University of British Columbia	2014 - 2015

Memberships in Professional Organizations

Doctors of BC (formerly named British Columbia Medical Association)
British Columbia Psychiatric Association
Canadian Medical Association, Honorary Member
Royal College of Physicians & Surgeons of Canada
American Psychiatric Association, Life Member
International Brain Injury Association
Canadian ADHD Resource Alliance
American College of Lifestyle Medicine

Professional Service and Experience

Extensive committee work for the:

- BC Medical Association (BCMA), since (2014) called *Doctors of BC*
- Royal Jubilee Hospital (GVHS; Vancouver Island Health Authority; now called Island Health)
- BC Psychiatric Association
- Canadian Medical Association

Negotiating Committee, Professional Association of Residents and Internes of BC (Established the first contract between BC Teaching Hospitals and PARI-BC)	1972 - 1974
Assistance for Impaired Doctors (Physician AID) Committee member, BCMA (Now this is called the Physician Health Program)	1980 - 1984 and 1997 - 2002
BCMA Computer Committee member, (Chair, 1986 - 1990) (Policy Development & Negotiation during Government-imposed mandatory computerized billing implementation for all BC physicians)	1984 - 1990
Member, Board of Directors, BCMA	1985 - 1991 and 2004 - 2012
Chairman of the Board of Directors, BCMA	1989 - 1990
Chair of General Assembly, BCMA	2008 - 2009
President-Elect, BCMA	2009 - 2010
President, British Columbia Medical Association	2010 - 2011
Past President, BCMA	2011 - 2012
Member, Computer Study Committee, BCMA (Negotiation of a $12 million compensation program for BC physicians affected by mandatory billing requirement; distribution of benefits and review of appeals)	1991 - 1992
Auditor, College Office Medical Practice Assessment Program (Peer Review) (Appointed by the College of Physicians & Surgeons of BC)	1992 - 1993
Consultant to the Superintendent of Motor Vehicles, (Drivers License medical suspension appeals, 151 cases)	1991 - 2008

Driving Advisement System (computerized testing of cognitive skills), certification	1992
Member, Emergency Medical Services Committee, BCMA (Chair, 2001 - 2007)	1994 - 2008
Elemental Driving Simulator operator training and certification	1996
Driver Fitness Advisory Group (OSMV), specialist representative for BCMA	~ 2000 - 2016
DriveABLE testing facility for Vancouver Island & Gulf Islands, proprietor	2002 - 2007
Certificate in Conflict Resolution, Justice Institute of British Columbia	1998
Certification as Comprehensive Family Mediator, Family Mediation Canada	1998 - 2008
Court Mediation Practicum Program (completed ten Small Claims Court mediations)	2004 - 2005
Member, BCMA Information Technology Policy Committee	2008 - 2012
Chair, BCMA CEO Search Committee	2011
Alternate member, Medical Services Commission	2009 - 2010 and 2011 - 2012
Invited Clinical Assessor for the Improved Alcohol Program Pilot Project, Office of the Superintendent of Motor Vehicles, Ministry of Transportation & Highways	2000 - 2001
Co-editor of the *Guide for Physicians in Determining Fitness to Drive a Motor Vehicle*, and then work in collaboration with the Office of the Superintendent of Motor Vehicles on the preparation of the 8th edition, published June 2010	2003 - 2010
Member, Scientific Editorial Board, Canadian Medical Association, for the 7th edition of *Determining Medical Fitness to Operate Motor Vehicles: CMA Driver's Guide* and for the 8th edition, published November 21, 2012; 9th edition in press	2005 - 2006 2012 – 2017
Physician Leadership Program, UBC Sauder School of Business, Cohort 3 graduate	2015
Chair, Council on Health Promotion, Doctors of BC	2015 – 2017
Member of the international Working Group tasked with updating the Section on Traumatic Brain Injury to current *evidence*-based guidelines. The Canadian Institutes of Health Research (CIHR) approved funding for a research grant entitled *A Collaborative International Knowledge Synthesis to Update Guidelines for Determining Medical Fitness to Operate Motor Vehicles*.	2015 - 2017
T.O.V.A. (Test of Variables of Attention) training and certification	2014

Other Public Service

Member, Victoria Adult Survivors (of Sexual Abuse) Services Advisory Committee	1992 - 1993
Member, Mental Health Task Force, Capital Region	1992 - 1993
Board Member, (one term as Secretary) Separation and Divorce Resource Centre	1997 - 1999
Member, Subcommittee on Hospital Liaison for Spousal Assault Support Services	1998 - 2001
Medical Safety Officer, Gorge Swim	2000 & 2001
Level II Official, Victoria International Triathlon	2001 - 2003
Member, Selkirk Montessori School Board of Directors	2014 - 2017
Design and continuing updating of www.drivesafe.com	2002 - 2013

(This website's content moved to www.drivesafe.info January of 2014 – September 2016, then was discontinued)

Other Qualifications

Certification by National Lifeguard Society (Pool option)	1995 - 2007
Certification in CPR AED use (Automated External Defibrillator)	2011 & 2016
Private Provider certification for *Fast ForWord* & *Reading Assistant* applications	2013 - 2017
Schwinn® Cycling Instructor Certification	2014
Certificate of Completion in Culinary Coaching, Institute of Lifestyle Medicine, Boston	2016 May

Teaching Experience

Clinical supervision of interns/residents at Royal Jubilee Hospital and private office
Education rounds at various sites in Greater Victoria Hospital Society 1976 - 2002
Guest lecturer at the University of Victoria, Psychology 430 (Abnormal Psychology) March 1998
Invited lecturer, Ministry Attorney General, Family Court Counsellors conferences 1999
Plenary speaker, Mediation Development Association of BC conferences 2003
Director and author of American Psychiatric Association peer-reviewed course on 2003 & 2004
Determining Medical Fitness to Drive: Relevant Issues for Psychiatrists
Keynote speaker, Trial Lawyers Association of BC on: 2011
Traumatic Brain Injury – Is it time for standardized assessment in the ER?
and on: *Neuroplasticity: the science of teaching old dogs new tricks.*
Invited speaker, 12th Annual CADDRA ADHD Conference, Ottawa October 2016
Update on Determining Medical Fitness to Drive in Patients Diagnosed with ADHD

Expert Opinion Experience

Preparation of comprehensive medical legal reports (primarily in the area of residual cognitive impairment after traumatic brain injury; also in Posttraumatic Stress Disorder cases).

Testifying as an expert witness in BC Provincial Court and BC Supreme Court in a number of cases.

Research Experience

Research assistant to Dr. George Woodwark, Royal Jubilee Hospital, Victoria, BC 1969
Project: ECG Telemetry of Coronary Ambulance Patients

Research assistant to Drs. Morton Low & Harry Klonoff. University of BC, Vancouver 1971 - 1972
Projects: to investigate the neurophysiological and behavioral effects of Marijuana, and effects of cannabis intoxication on automobile driving ability.

Phase III studies on the clinical effectiveness of paroxetine and venlafaxine 1992 - 1996
Phase III study on the clinical effectiveness of ziprasidone 2000 - 2002
Work with an international group of colleagues on a Knowledge Translation Project 2014 – 2017
leading to publication of a journal article on national-level guidelines on driving in 2015, with other collaborative work in progress on Traumatic Brain Injury

Professional Publications

"Monitoring of ambulance patients by radio telemetry." GM Woodwark, IA Gillespie.
Canad. Med. Ass. J., 102:1277-9, 1970

Author of the chapter on Psychiatric Disorders, and a section on Traumatic Brain Injury, in the 7th edition of the Canadian Medical Association's *Determining Medical Fitness to Operate Motor Vehicles: CMA Driver's Guide.* Published 2006 December 5. Please see below for revision date.

Report on Pandemic Preparedness Exercise in Cranbrook. BC Medical Journal. 2007 Apr. 49(3):146

Letter to the Editor, New England Journal of Medicine, comment on review article on "Concussion." N Engl J Med. 2007 Apr 26; 356(17):1788-9; author reply 1789.

Emergency Planning and Posttraumatic Stress Disorder. BC Medical Journal. 2007 Sep. 49(7):376

Invited book review on *The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Brain Science,* by N Doidge, for the Canadian Medical Association Journal's *The Left Atrium* section: – "Hope springs eternal in the human brain" Can. Med. Assoc. J., Dec 2007; 177: 1552 - 1553

Invited book review on *The Physician as Patient: a Clinical Handbook for Mental Health Professionals,* by Michael F. Myers, MD and Glen O. Gabbard, MD. (2008) for the Canadian Medical Association Journal's *Humanities* section: – "A shift in physician health" Can. Med. Assoc. J., Mar 2009; 180: 743

Author of the chapter on Psychiatric Disorders, and lead author of a chapter on Traumatic Brain Injury, in the 8th edition of the Canadian Medical Association's *Determining Medical Fitness to Operate Motor Vehicles: CMA Driver's Guide.* Published November 21, 2012.

Invited by Faculty of Medicine, Memorial University, Professional Development & Conferencing Services to be a member of the Planning Committee tasked with developing a web-based Continuing Professional Development (CPD) Module - *Getting Clear about Concussion Care,* published online December 18, 2013.

Invited by Faculty of Medicine, Memorial University, Professional Development & Conferencing Services to be Independent Reviewer of content for a CPD module entitled *Posttraumatic Stress Disorder: A Primer for Primary Care Physicians.* The PTSD course launched on the MDcme and CMA.ca portals on November 19, 2014 and a recertification revision was done in 2016.

An international study of the quality of national-level guidelines on driving with medical illness. M.J. Rapoport; K. Weegar; Y. Kadulina; M. Bedard; D. Carr; J.L. Charlton; J. Dow; I.A. Gillespie; C.A. Hawley; S. Koppel; S. McCullagh; F. Molnar; M. Murie-Fernandez; G. Naglie; D. O'Neill; S. Shortt; C. Simpson; H.A. Tuokko; B.H. Vrkljan; S. Marshall. QJM 2015; doi: 10.1093/qjmed/hcv038

Author of the revised chapter on Psychiatric Disorders for the 9th edition of the Canadian Medical Association's *Determining Medical Fitness to Operate Motor Vehicles: CMA Driver's Guide.* Approved for publication by the Scientific Editorial Board, May 2015. Published July 2017.

Preparing for an in-flight medical emergency. I. Gillespie, C. Rumball. BC Medical Journal. 2017 April 59(3):195-196.

Other Publications

The Computer Corner, regular bimonthly column in BC Medical News 1985 - 1989

Many committee reports for the hospital and BCMA, including advisory report to a Cabinet Task Force.

President's Comment regular column in BC Medical Journal for ten consecutive issues 2010 - 2011

Understanding ADHD – Island Parent magazine September-October 2014 issue.

Separate documentation of over 400 hours of training in conflict management available, on request.