

VERDICT OF CORONER'S JURY

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We

Michelle C. BERGERON	of	OTTAWA, ONTARIO
Stephen COOPER	of	OTTAWA, ONTARIO
Louise de MONTIGNY	of	OTTAWA, ONTARIO
Nicholas DUCIC	of	OTTAWA, ONTARIO
Joanne RICHARD	of	OTTAWA, ONTARIO

the jury serving on the inquest into the death of:

WHISSELLE, Roger

Aged 39 held at Canadian Human Rights Tribunal, 160 Elgin Street, Ottawa, Ontario

on the 28th day of **September, 2005**

by **Dr. B.E. Bechard**, Coroner for Ontario

having been duly sworn have inquired into and determined the following:

- | | |
|----------------------------|---|
| 1. Name of deceased: | Roger Whisselle |
| 2. Date and time of death: | 22:30 30 January 2004 |
| 3. Place of death: | Montfort Hospital, Ottawa, Ontario |
| 4. Cause of death: | Cardiac arrhythmia caused by ventricular hypertrophy |
| 5. By what means: | Natural causes |

FOREMAN

This verdict was received by me this 04th day of **October, 2005**

Dr. B.E. Bechard

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

Recommendation 1.

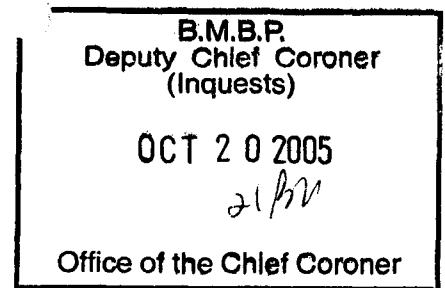
That the hospital review its procedures for informing a deceased patient's next of kin with a view to providing the family with increased, professional support, better and more information, in a timely fashion, regarding the circumstances surrounding the death.

Recommendation 2.

That the hospital review its procedures with a view to better incorporating the psychiatric floor (patients) within the medical system and procedures in place for other non-psychiatric patients.

CORONER'S EXPLANATION OF VERDICT
INQUEST INTO THE DEATH OF Roger Whisselle

Place: Canadian Human Rights Tribunal, 160 Elgin St, Ottawa
Date: From September 28th to October 4th, 2005.



It is traditional for the Presiding Coroner at an inquest to provide a synopsis of the events leading to the inquest and also provide background information. This makes reading the Jury's Verdict easier to understand by putting the Findings and Recommendations into their proper context.

This is based on my own understanding of the evidence and my interpretation of the Jury's Reasons. This is not to be considered actual evidence presented at the inquest. It is offered only to assist the reader. It is not intended in any way to replace the Jury's Verdict and it should be read in conjunction with the actual Verdict.

Presiding Coroner: Dr Benoit Bechard

Court Reporter: Ms Linda Lebeau, 381 McDermitt Dr, Rockland K4K 1K9. 613-298-1982

Crown Attorney: Mr George Dzioba

Coroner's Constable: Cst Tom Bond, Ottawa Police Service

Persons with Standing: Mr John A. Webster, Counsel Ms Louise Whisselle, sister of the Deceased

Mr Daniel Boivin, Counsel for the physicians

Mr Pierre E. Roger, Counsel for the Montfort Hospital

Synopsis of Events:

Mr Roger Whisselle was admitted to the psychiatric unit at the Montfort Hospital on January 28th, 2004 suffering from acute manic phase of a previously diagnosed bi-polar disorder. He had been admitted to the Montfort for the same complaint in December 2003 and had been discharged in mid-January. He had been also admitted for the same disorder twice before in British Columbia.

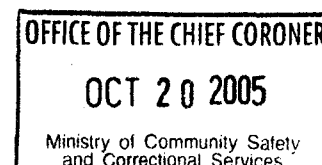
At the December 2003 admission, he was found to have a low O2 saturation when he was evaluated in the emergency room. A respiratory investigation revealed that Mr Whisselle suffered from hypoventilation syndrome secondary to obesity. The respirologist testified that Mr Whisselle was compensating adequately and that his respiratory status was stable. An ECG revealed mild left ventricular hypertrophy but testimony by a cardiologist used as an expert witness was that this would not have been sufficient to prompt further investigation.

On the afternoon of January 30th, Mr Whisselle was quite agitated and a review of his chart seemed to indicate that he had not slept much if at all since his admission on the 28th. After he refused oral medication, he was given Haldol 10mg im and Ativan 2mg im. He went back to his room and fell asleep. He was observed at least hourly and was found sleeping, everytime. It was decided not to disturb him since he had been awake for so long. At the 9:00pm medication round, he was still asleep. His medication was skipped. He was found at 10:30pm VSA. His hands were cold and he had some facial cyanosis. His body was observed to be still warm. Resuscitation attempts were made, to no avail.

The cardiac Pathologist testified that Mr Whisselle suffered from moderate left ventricular hypertrophy and that this condition can give rise to sudden arrhythmia and sudden death.

Recommendations:

1. That the hospital review the procedures for informing a deceased patient's next-of-kin with a view to providing the family with increased professional support, better information, in a timely fashion, regarding the circumstances surrounding the death.



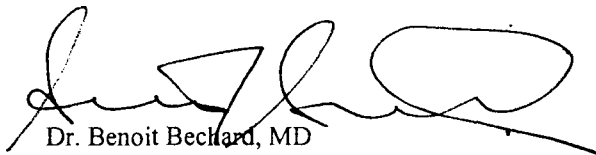
Coroner's explanation: It was quite obvious to me from pre-inquest contacts with the family that a number of misapprehensions had arisen and that the family had become suspicious that they were not told all there was to know about Mr Whisselle's death. The jury picked-up on that although there was not a lot of testimony on this topic. They obviously felt that some structured family support team such as pastoral care, would have lessened the grief and misunderstanding of the family.

2. That the hospital review its procedures with a view to better incorporating the psychiatric floor (patients) within the medical system and procedures in place for other non-psychiatric patients.

Coroner's explanation: We heard testimony that after Mr Whisselle had been identified as suffering from hypoventilation syndrome that his medical condition was supervised by a family doctor serving as an hospitalist on the psychiatric floor. This doctor did not attend Mr Whisselle at the time of the second admission. There was a submission that this service for the psychiatric unit be beefed up. There was no testimony indicating the hospitalist had been unable to attend or that his attendance would have altered the course of events leading to Mr Whisselle's death.

In closing, I would like to stress once again that this document was prepared solely to assist interested parties in understanding the Jury Verdict. It is not the Verdict nor should it be read separately from the Verdict.

Likewise any comments regarding the evidence are my personal recollection and should not be seen as actual evidence. If I have made any gross errors I apologize and if this is brought to my attention, I will gladly correct the error.

A handwritten signature in black ink, appearing to read 'Dr. Benoit Becharard', with a large, stylized flourish extending to the right.

Dr. Benoit Becharard, MD
Coroner