ONTARIO HOSPITAL ASSOCIATION

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BULLETIN

December 11, 2007

For the Attention of
Hospital CEOs and OHA Board of Directors

From Anthony Dale, Vice President, Policy and Public Affairs

OHA Responds to Dupont-Daniel Inquest

Today, a Coroner's jury released its recommendations resulting from the Dupont-Daniel inquest.

The OHA sought and received standing at the inquest, and submitted a recommendation regarding the *Public Hospitals Ac*t. The OHA was pleased that a review of the *Public Hospitals Act* was included as the first in the list of 26 recommendations.

Attached to this bulletin are the complete jury recommendations and a media statement issued by the OHA in response to them. The OHA plans to carefully review the recommendations, and will update Members about its review in the time ahead.

Please contact Cara Francis, OHA Public Affairs, by telephone at 416-205-1371 or by email at cfrancis@oha.com, should you have any questions.

[Scroll down for the actual verdict.]

The Coroner's Act - Province of Ontario / Loi sur les coroners – Province de l'Ontario

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

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

Surname / Nom de famile	Given names / Prénom
DUPONT	***Lori***

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

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

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

having been duly sworn, have inquired into and determined the following:/ avons enquêté at 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***

DOriginal signed by: Foreman/Président du jury

Original signed by jurors/jurés

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

Original signed by Coroner

The Coroner's Act - Province of Ontario / Loi sur les coroners – Province de l'Ontario

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

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

Surname / Nom de famile	Given names / Prénom
DANIEL	***Dr. Marc***

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

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

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

having been duly sworn, have inquired into and determined the following:/ avons enquêté at 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:

    - 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.

    - Review the parameters for the approval of credentialing applications and for re-appointments to the medical staff.

    - Develop a process or mechanism for the early identification of and response to Disruptive Physician Behaviour, including timely and effective disciplinary actions.

    - Simplify the process for non-approval of re-appointment, immediate suspension or revocation of Hospital privileges and for the initiation of probationary status.

    - 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.

    - 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.

    - 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.

    - 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.

    - 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:

2. 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:

   - 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.

   - 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.

   - 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.

   - 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.

   - 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.

   - 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.

   - 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.

   - 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).

   - 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.

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

   - 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).

   - 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.

   - 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:

3. 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:

- The PHP should have a robust assessment programme and clear guidelines for monitoring, reporting and follow-up.
- 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.
- 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.
- The PHP should develop standard templates for treating clinicians, and require them to report treatment and outcomes back to the PHP.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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"):

4. 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:

- 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.

- 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.

- 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.

- 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.

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

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

- 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.

- 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:

5. 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

6. 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").

7. 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:

8. 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.

9. 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:

10. 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.

11. 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.

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

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

14. 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.Iovino-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

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. 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

23. 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.

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

25. 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

26. 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

ONTARIO HOSPITAL ASSOCIATION

MEDIA RELEASE

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December 11, 2007

Statement from the Ontario Hospital Association re: Dupont Inquiry Recommendations

(Toronto) – "On Tuesday, December 11, 2007, the jury in the coroner's inquest into the death of Lori Dupont, a nurse who worked at the Hotel Dieu Grace Hospital in Windsor, released its verdict and recommendations.

The OHA welcomed the jury's recommendations and intends to review them very carefully in the time ahead. We were particularly pleased that a review of the *Public Hospitals Act* was included as the first in the list of 26 recommendations.

The OHA intends to discuss the recommendations with our health care partners and work collaboratively moving forward."

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For more information:
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416-205-1371