



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

Micheline Brousseau of Ottawa, Ontario
de

Rima Hamoui of Ottawa, Ontario
de

Rachelle Demers of Ottawa, Ontario
de

Alison Clark Milito of Ottawa, Ontario
de

Alain Brunet of Ottawa, Ontario
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: Hatt | Given names / Prénom: Wade Lamont

aged **41** held at **Coroner's Inquest Courts, Ottawa, Ontario**
 âgé(e) de qui a été menée à

from the **30th of October** to the **3rd of November** 2006
 du a la

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 et avons déterminé ce qui suit:

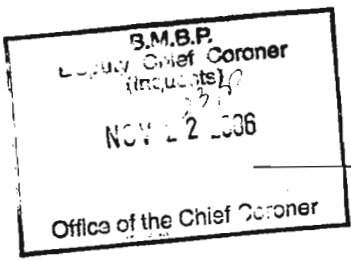
1. Name of deceased / Nom du (de la) défunt(e): **Wade Lamont Hatt**
2. Date and time of death / Date et heure du décès: **October 15, 2005 between 01:30hrs and 06:00hrs**
3. Place of Death / Lieu de décès: **598 Kirkwood Ave. Unit 2, Ottawa, Ontario**
4. Cause of death / Cause du décès: **Oral overdose of prescribed Methadone medication with severe bilateral acute pulmonary congestion and edema**
5. By what means / Circonstances entourant le décès: **Accident**

Alison Clark Milito
Original signed by: Foreman/Président du jury

Wade Lamont Hatt
Rachelle Demers
Alain Brunet

Micheline Brousseau
Original signed by jurors/jurés

The verdict was received on the **3rd** day of **November** 20 **06**
 Ce verdict a été reçu par moi le



[Signature]
Original signed by Coroner

JURY RECOMMENDATIONS

1. *The Ontario Addiction Treatment Centres (OATC) need to ensure that their clinic staff receive proper training on the policies and procedures of the clinic, as outlined in the Policies and Procedures manual, as well as being fully aware of their respective responsibilities.*

Rationale: Evidence showed that the two nurses present during the incident lacked knowledge of the clinic's policies and procedures, and had not recalled reviewing them thoroughly.

2. *OATC staff should serve only one patient at the counter at a time under all circumstances.*

Rationale: To minimize the risk of an error in dosage administration.

3. *OATC patients should be served by the same nurse during their visit whenever possible.*

Rationale: To minimize confusion and improve lines of communication.

4. *OATC patients should be served separately in a private area away from the public waiting room.*

Rationale: To enhance patient confidentiality and reduce distractions.

5. *OATC nurses must witness patient reading label on bottle and have them confirm their name and dosage is correct by initialing an acknowledgement.*

Rationale: To minimize the risk of giving the wrong dose to the wrong patient.

6. *Ontario pharmacies should increase the font size of the patient name and dosage amount on the labels of methadone bottles.*

Rationale: To minimize the risk of giving the wrong dose to the wrong patient.

7. *The OATC should consider storing methadone in three separate cabinets according to dosage (<50 mg), (50-100mg), (>100mg), and have these cabinets located in a secure area, out of patients' view.*

Rationale: To minimize the risk of giving the wrong dose to the wrong patient.

8. *OATC staff should confirm patients' contact information (address & phone number) on a daily basis.*

Rationale: Proper documentation is essential to the proper and well informed care of a patient.

9. *The College of Physicians and Surgeons of Ontario should revise their Methadone Maintenance Guidelines - Appendix H - to advise patients on avoiding overdose throughout their methadone treatment.*

Rationale: The current guideline (Appendix H) places the focus exclusively on the first two weeks of methadone treatment. Evidence showed that overdoses could occur at any time throughout the treatment.

10. *Relevant governing/regulating bodies (ie. College of Pharmacists, College of Physicians and Surgeons of Ontario) should jointly review the method by which methadone prescriptions are filled and determine the safest option for all involved parties (ie. Measured vs. non-measured bottle; filled partly with juice/fully with juice/no juice added).*

Rationale: Evidence was given that the current method is not necessarily the safest option available.

- 11. The Methadone Maintenance Guidelines of the College of the Physicians and Surgeons of Ontario should be revised to include information for physicians on the management of methadone overdose.**

Rationale: Evidence showed that such a management plan does not exist in the current guidelines and that these guidelines are material referenced by OATC doctors.

- 12. The OATC should develop a clear, succinct overdose incident response protocol to be made available to clinic staff, posted in each room of the clinic and added to their Policies and Procedures Manual.**

This needs to include, but not limited to, the following:

- a. Inform the patient immediately that he/she has taken an overdose.*
- b. Contact doctor immediately.*
- c. Strongly encourage the patient go to the Emergency Room.*
- d. Explain why going to the Emergency Room is highly recommended (there is a high risk of death; clinic not equipped with a saturation monitor nor a ventilator).*
- e. Preserve all physical evidence and ensure proper documentation of incident.*
- f. Send relevant documentation to the Emergency Room.*

Rationale: Evidence showed that there was a lack of coordination, organization and communication in dealing with this methadone overdose. Severity of situation needs to be clearly communicated and re-enforced to the patient. Evidence also showed that the incident was poorly documented and that evidence was not gathered and secured.

- 13. The OATC should develop an easy-to-understand information sheet, for the benefit of patients, regarding signs of methadone toxicity. This should be made easily available in printed format to the clinic patients.**

Rationale: The current Methadone Overdose Protocol in the manual is currently 3+ pages in length and is written for a medical profession audience.

- 14. The College of Physicians and Surgeons of Ontario and the OATC need to jointly develop a protocol to follow when a patient refuses to go to the hospital.**

This needs to include, but not limited to, the following:

- a. Have patient sign waiver against medical advice if refuse to go to hospital.*
- b. Have patient sign letter acknowledging detailed advice given regarding methadone toxicity risks and refusal to take that advice.*
- c. Give patient the information sheet regarding signs of methadone toxicity.*
- d. Provide written advice regarding at-home monitoring and risks involved.*

Rationale: The current OATC protocol provides little direction on how to handle an overdose situation when the patient refuses to go to hospital.

- 15. The OATC need to develop a system for follow-up contact with patients who have taken an overdose of methadone.**

Rationale: Evidence showed that no formal method to follow-up with an overdose patient existed at the clinic.

- 16. The College of Physicians and Surgeons of Ontario and the OATC should take initiatives to educate Emergency Department staff with respect to dealing fairly with methadone overdose patients.**

Rationale: Evidence was presented that a bias exists in Emergency Rooms towards methadone patients.

Verdict Explanation

Inquest into the death of Wade Lamont HATT,

Held at the Canadian Human Rights Tribunal Hearing Room, 11th floor, 161
Elgin Street, Ottawa, ON
By Dr. A.L. McCallum, Coroner for Ontario

Opening Comment

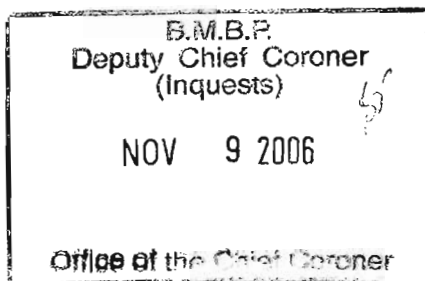
I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict of the jury 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. George Dzioba |
| Investigating officers: | Det. Grant Cotie Ottawa Police Service |
| Coroner's Constable: | Constable D. MacMillan |
| Court reporter: | Ms. Tammy Archer, RR#2, Codrington, ON K0K 1R0 613-475-4708 |

Parties with standing:

| NAME OF PARTY | REPRESENTED BY: (COUNSEL OR AGENT) |
|------------------------------------|---|
| 1. The Family of Wade Lamont | Ms. Donna Crabtree Solway Wright LLP Suite 900 427 Laurier Ave. W. Ottawa, ON K1R 7Y2 |
| 2. Ont. Addiction Treatment Clinic | Mr. Wayne Brynaert, Ms. Meghan O'Brien Gowlings Lafleur Henderson Suite 2600 P.O.Box 466 Station D 160 Elgin St. Ottawa, ON K1P 1C3 |



SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

Mr. Hatt was 41 years old at the time of his death. He was a client of the Ontario Addiction Treatment Clinic where he received methadone treatment for an addiction to Oxycontin ®. On October 14th, 2005, Mr. Hatt attended the clinic with his partner. She was also a client, but was receiving a much larger dose of methadone. The jury heard evidence that they both were served their doses at the clinic counter at the same time, whereupon the registered practical nurse who had dispensed the dose recognized that the doses had been transposed, with Mr. Hatt receiving a substantial part of his partner's dose of 160 mg, while she received his 15 mg dose. The jury heard conflicting testimony as to the exact type of bottle used to dispense the methadone and the precise amount of methadone ingested. Several bottles were introduced as exhibits. There was no indication on the bottles, except for the label (in relatively small print), that there were significantly differing doses of methadone therein.

The testimony heard by the jury indicated that Mr. Hatt was asked to self-induce vomiting immediately, which he attempted twice. Testimony was conflicting as to the actual amount vomited. The doctor on duty at the clinic testified that he counseled Mr. Hatt to go to the hospital for observation and/or treatment, but the partner did not recall the doctor being so specific. As well, while the clinic staff testified that the atmosphere after the overdose was "serious", the partner felt, in her testimony, that the incident was not treated as a serious event.

Clinic staff gave testimony that they were aware that the Clinic had a Policy and Procedure dealing with overdose, but they were not familiar with details of the policy. Training of new staff consisted of being given the Policy and Procedure Manual and on-the-job training. Physicians who administer methadone, in contrast, attend a two-day mandatory course given by the College and Physicians and Surgeons of Ontario based on the College's Methadone Maintenance Guidelines. These Guidelines were introduced as an exhibit. The jury were advised through testimony that the Guidelines do not contain a section on the management of overdose in established clients (there is a section on overdose during the initiation of treatment).

Staff members indicated on the stand that they were aware that the Clinic Policy dictated that the on-call physician was to be called. This was done, and the on-call physician responded from his office in another city, and gave advice that Mr. Hatt should be induced to vomit and advised to go to hospital. However, the on-call physician and the on-site physician, who had

only recently begun treating methadone clients, did not speak directly to each other nor did the on-call physician speak to Mr. Hatt or his partner.

In any case, all who gave evidence agreed that Mr. Hatt declined to go to hospital, saying that he would go if he became symptomatic. He was not asked to complete any documentation that he was declining medical advice. The testimony from the several witnesses who were present was in agreement that the advice given to Mr. Hatt and his partner was that his breathing should be observed, but there was no indication in the testimony that any parameters for observation were given. He and his partner were further advised that unusual drowsiness or "nodding off" should result in Mr. Hatt going to hospital. His partner testified that she did not apprehend the risk to life in this situation. She gave evidence that the doctor on duty had told her that Mr. Hatt would be "out of the woods" by about 11 pm.

Mr. Hatt went home, and went to sleep at about 1730h, according to the testimony of his partner. She stated that she was able to rouse him about an hour later, and that he could be heard snoring in the later hours of the evening. She last heard him snoring about 0130h on the 15th of October when she retired for the night. She awoke some short time thereafter, possibly around 0300h, and moved out of the bedroom to the living room couch, due to the snoring noise.

Around 0600h, Mr. Hatt's partner testified that she awoke and found Mr. Hatt cold and unresponsive. She called 911, but Mr. Hatt could not be resuscitated. The pathologist who conducted the autopsy and toxicologist testified that the death was due to an overdose of methadone. A major metabolite of cocaine was the only other drug of significance found on toxicologic analysis of Mr. Hatt's blood.

An inquest was called to examine issues of safety and training related to the administration of methadone.

The jury heard testimony from an expert who uses methadone to treat his patients for chronic pain. This expert testified that Mr. Hatt would have been intolerant to the inadvertent overdose of 160 mg of methadone, as his dose had been tapered down to 15 mg and tolerance to methadone is lost relatively quickly. He also testified that the use of vomiting would have not been an efficacious method of removing methadone from the stomach and small intestine. He commented that activated charcoal, plus observation in a setting where continuous oximetry is available (skin monitoring of oxygen saturation is a sensitive indicator of respiratory depression which is the toxic effect of methadone that leads to death). This expert also testified that individuals skilled in observing overdose patients must monitor the patient. Finally, the expert testified on the issue of informed

consent. He stated that a competent patient who has ingested a long-acting opiate such as methadone and has yet to show any sign of intoxication cannot be forced to go to hospital against his will. However, the same patient, if incapacitated due to the effects of the overdose, could later be treated. The expert commented on the dilemma faced by the physician in this circumstance.

During the course of the inquest, the jury heard the testimony of nine witnesses. As well, thirteen exhibits were put before the jury.

VERDICT

| | | |
|----|---|--|
| 1. | Name of deceased Nom du (de la) défunt(e) | Wade Lamont Hatt |
| 2. | Date and time of death Date et heure du décès | October 15, 2005 between 01:30hrs and 06:00hrs |
| 3. | Place of Death Lieu de décès | 598 Kirkwood Ave. Unit 2, Ottawa, Ontario |
| 4. | Cause of death Cause du décès | Oral overdose of prescribed Methadone medication with severe bilateral acute pulmonary congestion and edema |
| 5. | By what means Circonstances entourant le décès | Accident |

RECOMMENDATIONS

- 1. The Ontario Addiction Treatment Centres (OATC) need to ensure that their clinic staff receive proper training on the policies and procedures of the clinic, as outlined in the Policies and Procedures manual, as well as being fully aware of their respective responsibilities.***

Rationale: Evidence showed that the two nurses present during the incident lacked knowledge of the clinic's policies and procedures, and had not recalled reviewing them thoroughly.

Coroner's Explanation: I believe that the jury considered this an important safety issue. The staff did not appear on the stand to have a clear understanding of the correct procedure to follow should an overdose occur beyond informing the doctor.

- 2. OATC staff should serve only one patient at the counter at a time under all circumstances.***

Rationale: To minimize the risk of an error in dosage administration.

Coroner's Explanation: Clinic staff testified that the distraction caused by the two patients at the counter simultaneously contributed to the mix-up in the doses.

3. ***OATC patients should be served by the same nurse during their visit whenever possible.***

Rationale: To minimize confusion and improve lines of communication.

Coroner's Explanation: This recommendation appears to address the issue of continuity of care. A different nurse treated Mr. Hatt after he had received the overdose.

4. ***OATC patients should be served separately in a private area away from the public waiting room.***

Rationale: To enhance patient confidentiality and reduce distractions.

Coroner's explanation: Here the jury is making a recommendation aimed both at enhancing confidentiality and allowing better distinguishing marks on methadone bottles. The jury heard testimony that having such marks would lead to other patients deducing the dose that another patient is receiving.

5. ***OATC nurses must witness patient reading label on bottle and have them confirm their name and dosage is correct by initialing an acknowledgement.***

Rationale: To minimize the risk of giving the wrong dose to the wrong patient.

6. ***Ontario pharmacies should increase the font size of the patient name and dosage amount on the labels of methadone bottles.***

Rationale: To minimize the risk of giving the wrong dose to the wrong patient.

7. ***The OATC should consider storing methadone in three separate cabinets according to dosage (<50 mg), (50-100mg), (>100mg), and have these cabinets located in a secure area, out of patients' view.***

Rationale: To minimize the risk of giving the wrong dose to the wrong patient.

Coroner's Explanation: Recommendations 5, 6 and 7 are all aimed at making the system of methadone administration safer by preventing and/or minimizing the chance of misreading the label and giving the wrong dose to the wrong patient.

8. ***OATC staff should confirm patients' contact information (address & phone number) on a daily basis.***

Rationale: *Proper documentation is essential to the proper and well informed care of a patient.*

Coroner's Explanation: *Evidence was heard that the telephone number used by a staff member to attempt to contact Mr. Hatt on the evening of the 14th was out of date by a year.*

- 9. The College of Physicians and Surgeons of Ontario should revise their Methadone Maintenance Guidelines – Appendix H – to advise patients on avoiding overdose throughout their methadone treatment.**

Rationale: *The current guideline (Appendix H) places the focus exclusively on the first two weeks of methadone treatment. Evidence showed that overdoses could occur at any time throughout the treatment.*

Coroner's Explanation: *This recommendation is aimed at the Guidelines lack of a section on overdose in the stable or weaning stage of methadone maintenance.*

- 10. Relevant governing/regulating bodies (ie. College of Pharmacists, College of Physicians and Surgeons of Ontario) should jointly review the method by which methadone prescriptions are filled and determine the safest option for all involved parties (ie. Measured vs. non-measured bottle; filled partly with juice/fully with juice/no juice added).**

Rationale: *Evidence was given that the current method is not necessarily the safest option available.*

Coroner's explanation: *This recommendation arises from evidence that the supplying pharmacy, apparently based on the College of Pharmacy policy, now supplies the methadone diluted in a partly filled bottle. Previously, the methadone was supplied in the correct dose undiluted which staff testified allowed them to quickly verify levels of methadone visually.*

- 11. The Methadone Maintenance Guidelines of the College of the Physicians and Surgeons of Ontario should be revised to include information for physicians on the management of methadone overdose.**

Rationale: *Evidence showed that such a management plan does not exist in the current guidelines and that these guidelines are material referenced by OATC doctors.*

Coroner's explanation: *See explanation for Recommendation 9.*

- 12. The OATC should develop a clear, succinct overdose incident response protocol to be made available to clinic staff, posted in each room of the clinic and added to their Policies and Procedures Manual.**

This needs to include, but not limited to, the following:

- a. *Inform the patient immediately that he/she has taken an overdose.*
- b. *Contact doctor immediately.*
- c. *Strongly encourage the patient go to the Emergency Room.*
- d. *Explain why going to the Emergency Room is highly recommended (there is a high risk of death; clinic not equipped with a saturation monitor nor a ventilator).*
- e. *Preserve all physical evidence and ensure proper documentation of incident.*
- f. *Send relevant documentation to the Emergency Room.*

Rationale: Evidence showed that there was a lack of coordination, organization and communication in dealing with this methadone overdose. Severity of situation needs to be clearly communicated and re-enforced to the patient. Evidence also showed that the incident was poorly documented and that evidence was not gathered and secured.

Coroner's Explanation: This recommendation appears to be the jury's response to evidence that the bottles were not retained or documented, and the incident report did not have a great deal of detail. Further, there was evidence from Mr. Hatt's partner that she was not given detailed information or instructions as to the severity and nature of the overdose.

13. *The OATC should develop an easy-to-understand information sheet, for the benefit of patients, regarding signs of methadone toxicity. This should be made easily available in printed format to the clinic patients.*

Rationale: The current Methadone Overdose Protocol in the manual is currently 3+ pages in length and is written for a medical profession audience.

Coroner's Explanation: The jury heard that there is no information sheet to be handed out to overdose patients, but that information sheets can be useful to assist in the home monitoring of patients. A possible model cited was the Head Injury Routine given to caregivers of patients with concussion.

14. *The College of Physicians and Surgeons of Ontario and the OATC need to jointly develop a protocol to follow when a patient refuses to go to the hospital.*

This needs to include, but not limited to, the following:

- a. *Have patient sign waiver against medical advice if refuse to go to hospital.*
- b. *Have patient sign letter acknowledging detailed advice given regarding methadone toxicity risks and refusal to take that advice.*
- c. *Give patient the information sheet regarding signs of methadone toxicity.*
- d. *Provide written advice regarding at-home monitoring and risks involved.*

Rationale: *The current OATC protocol provides little direction on how to handle an overdose situation when the patient refuses to go to hospital.*

Coroner's Explanation: *Self explanatory.*

- 15. The OATC need to develop a system for follow-up contact with patients who have taken an overdose of methadone.**

Rationale: *Evidence showed that no formal method to follow-up with an overdose patient existed at the clinic.*

Coroner's Explanation: *This recommendation relates to the evidence that there was no formal follow-up plan in place to monitor Mr. Hatt once he had left the Clinic.*

- 16. The College of Physicians and Surgeons of Ontario and the OATC should take initiatives to educate Emergency Department staff with respect to dealing fairly with methadone overdose patients.**

Rationale: *Evidence was presented that a bias exists in Emergency Rooms towards methadone patients.*

Coroner's Explanation: *This recommendation deals with the testimony of the addiction physicians that Emergency Department personnel are not disposed towards treatment of addicts, because of the attendant difficulties among this group of patients regarding behaviour and drug-seeking. However, the jury recognized that these patients are also vulnerable, and therefore, a concerted plan must be developed so that they can seek needed treatment. In this case, Mr. Hatt may not have wanted to go to the Emergency Department because of his perception that he would not be welcome.*

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's 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 have made a gross error in my recollection of the evidence or a conclusion of the jury, it would be greatly appreciated if it could be brought to my attention and I will correct the error forthwith.



Andrew McCallum, MD
Presiding Coroner