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Hospital Failed Nurse, Inquest Told

By Doug Schmidt, Windsor Star (dschmidt@thestar.canwest.com or 519-255-5586)

Hotel-Dieu Grace Hospital managers were among many who knew about the dangers nurse Lori Dupont faced from a stalking and harassing doctor, and there were close to 40 “critical events” before her murder when action could have been taken, but wasn’t, an expert on domestic violence told a coroner’s inquest Thursday.

“At least four-dozen people know Lori Dupont is facing very difficult and dangerous circumstances. What’s unique about this tragedy is ... clearly a lot of people knew an awful lot,” said Dr. Peter Jaffe, a psychologist and director of the London-based Centre for Research on Violence Against Women & Children.

One of the last of 53 witnesses to be heard at the inquest into the November 2005 stabbing death of Dupont and subsequent suicide of her killer, anesthetist and ex-boyfriend Dr. Marc Daniel, Jaffe was blunt about the many missed opportunities to help the endangered nurse.

While mindful that a coroner’s inquest is not about assigning blame, Jaffe testified there was “overwhelming information” that Daniel should not have been allowed back to work after an earlier suicide attempt in February 2005. What followed was a “pattern of stalking and intimidating behaviour,” he said in a report for the jury based on his review of the case.

At least a dozen hospital supervisors and managers were given information about Daniel’s bad behaviour, said Jaffe. He said it was “clearly less than thorough” for the psychiatrist treating Daniel to simply rely on the mentally ill doctor’s word to gauge his readiness to return to work. And the justice system’s handling of Dupont’s much-delayed peace bond application “clearly wasn’t good enough.”

Outside authorities should have been brought in after Dupont told her employers of the note and compromising photo of her Daniel posted on her vehicle: “If the police had been notified in my jurisdiction ... it would have been treated as criminal harassment.”

Jaffe cited “at least 84 opportunities” when anyone from the family and police to employer could have intervened. “If it’s not dealt with ... it will escalate,” he said of incidents of domestic violence.

“Doing nothing says something. It really indicates that you condone and accept that behaviour,” Jaffe said.

Top Hotel-Dieu managers have testified at the inquest that they focused on rehabilitating a doctor they deemed mentally ill rather than disciplining him for his much-documented disruptive and disturbing behaviour. Jaffe criticized that hospital response, arguing that both aspects should have been dealt with.

“Depression is no excuse for sexual harassment; it’s no excuse for abuse.

“If you’re fit to be allowed back to work ... you’re then also fit to be held accountable for misconduct,” he said.

Reporting Daniel’s behaviour should not have rested solely on the victim, he said. “Clearly, in the workplace, the onus is on the managers,” said Jaffe, adding: “At the end of the day, the responsibility has to lie with the employer.”

Jaffe said the statement given by Daniel’s wife Susan to police the day after Dupont’s murder was a “textbook example of battered behaviour.” The statement, read out Wednesday, described Daniel as a troubled individual being tormented by others rather than the picture that had so far been portrayed at the inquest of a controlling and abusive individual.

When told by nurses’ union lawyer Elizabeth McIntyre that only a quarter of Hotel-Dieu’s doctors have taken the domestic violence training implemented since Dupont’s murder two years ago, said it’s important that they “be part of the same team.

“The more the doctors push back, the more I would worry about them,” he said.

After hearing from more than 50 witnesses over the past 10 weeks, the four-person jury will spend Monday hearing submissions from lawyers for the various parties with standing. Coroner Dr. Andrew McCallum is expected to give his closing instructions on Tuesday before the jury retires to compile its set of recommendations on what needs to be done to help prevent a similar tragedy in the future.

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