# SUMMARY

## DR. KARIN ELAINE KERFOOT (CPSO# 96461)

### 1. Disposition

On October 15, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required psychiatrist Dr. Kerfoot to appear before a panel of the Committee to be cautioned with respect to her assessment of suicide risk, factors for certification under the Mental Health Act, and the fundamental place of assessment and monitoring for the possibility of a major depressive episode and psychotic symptoms in the assessment and clinical management of a patient presenting with mood symptoms and suicidality, including in the context of substantial comorbid substance use and situational stressors. The Committee also asked Dr. Kerfoot to submit a written summary of what she had learned on the same topic.

### 2. Introduction

A family member of the patient complained to the College that Dr. Kerfoot's care resulted in the patient's death by suicide.

Dr. Kerfoot responded that she did not have sufficient grounds to detain the patient involuntarily on a Form 1 under the Mental Health Act, and set out her reasons for that conclusion.

### 3. Committee Process

A Mental Health Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in

Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

## 4. Committee's Analysis

The Committee decided that Dr. Kerfoot had sufficient grounds to complete a Form 1 based on the patient's medical history and presentation. In reviewing the patient's medical records, the Committee concluded that there were certain factors in his medical history that should have elevated Dr. Kerfoot's level of concern, even if the patient did deny any current suicidal ideation at the time she assessed him. The Committee also found that Dr. Kerfoot should have more thoroughly assessed and monitored the patient, and that further investigations may have led to possible changes in her management of the patient.

The Committee recognized that Dr. Kerfoot did provide the patient with encouraging advice regarding the value of inpatient admissions and presentation at an emergency room, if required, and acknowledged that it is impossible for mental health professionals to predict the occurrence of suicide attempts. However, in this case, the Committee felt the patient's pattern of behaviour and other significant factors should have marked his suicide risk as high at the time that he saw Dr. Kerfoot.

Overall, the Committee determined that Dr. Kerfoot's care in this case was not adequate in respect to her assessment of the patient's suicide risk, her failure to recognize that she had sufficient grounds to certify the patient under the Mental Health Act, and her monitoring and assessment of this patient. Further, the Committee was concerned that Dr. Kerfoot did not appear to have insight regarding these deficiencies.