Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury

We the undersigned

H.C.	of	***Toronto***
D.H.	of	***Toronto***
C.F.	of	***Toronto***
T.S.	of	***Toronto***
T.E.	of	***Toronto***

the jury serving on the inquest into the death of :

Surname:	Given names:
JAMES	***Jeffrey***

Aged: ***34 yr.*** held at ***Coroner's Inquest Court, 15 Grosvenor Street, Toronto, Ontario***

From the ***15th September*** to the ***10th October*** 20 ***08***

By Dr. ***A. E. Lauwers*** Coroner for Ontario

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

1.	Name of deceased	***Jeffrey James***
2.	Date and time of death	***July 13, 2005 @ 17:18 hours***
3.	Place of Death	***Toronto Western Hospital, Toronto, Ontario***
4.	Cause of death	***Acute Pulmonary Thromboembolism in a man with medical restraint***
5.	By what means	***natural***

Original signed by: Foreman

Original signed by jurors

The verdict was received on the ***10th*** day of ***October*** 20 ***08***

Original signed by Coroner

INQUEST INTO THE DEATH OF JEFFREY JAMES: JURY RECOMMENDATIONS

We the jury recommend the following:

Accreditation Canada (formerly Canadian Council on Health Services Accreditation CCHSA)

1. That Accreditation Canada should set as a standard for accreditation, a required organizational practice that health care facilities providing psychiatric care should develop reporting mechanisms and practices that track all incidents of physical restraint involving psychiatric patients. This could fall under the auspices of "Required Organizational Practices, Patient Safety, Risk Assessment".

Centre for Addiction and Mental Health (CAMH)

2. That CAMH continue to aspire to provide care to clients/consumers/survivors in a restraint free environment.

3. That consistent with its leadership role, CAMH should share with all psychiatric and schedule 1 facilities in Ontario, its:

- 3.1 Restraint Minimization Task Force May 30th, 2008 Final Report.
- 3.2 Client Bill of Rights.
- 3.3 Least Restraint Policy.

4. That CAMH should take a leadership role with all psychiatric and schedule 1 facilities in Ontario to:

- 4.1 Establish best practices guidelines for restraint.
- 4.2 Discuss restraint minimization techniques and practices.
- 4.3 Develop a data collection system regarding incidents of restraint use.

This data should be reviewed and compiled annually and presented in a report accessible to the public on line and be compliant with the Personal Health Information and Protection of Privacy Act, 2004. That CAMH should develop a business plan to be presented to the Ministry of Health and Long Term Care who should provide sufficient funding for CAMH to conduct this important work.

5. That CAMH should redesign all forms related to the charting of patients in restraint to reduce complexity and ensure compliance with written policy, in order to ensure that all aspects of written policy are carried out.

6. That CAMH should ensure that counseling and emotional supports are made available to patients on a unit following the death of a client/consumer/survivor.

7. That CAMH should ensure that all health service providers are provided mandatory in-service education on the minimization of restraints, the use of restraints, and the medical risks associated with restraints including pulmonary embolism.

8. That CAMH should ensure that all health service providers are provided with in-service education with respect to the Jury's Verdict and Recommendations.

Psychiatric and Schedule 1 Facilities

Guiding Principles

9. That all psychiatric and schedule 1 facilities in Ontario should aspire to provide care to clients/consumers/survivors in restraint free environments.

10. That all psychiatric and schedule 1 facilities in Ontario should review the CAMH's Client Bill of Rights. In facilities where a client Bill of Rights does not exist, one should be created and modeled after CAMH's Client Bill of Rights.

11. That all psychiatric and schedule 1 facilities in Ontario should review the CAMH's, "Restraint Minimization Task Force May 30th, 2008 Final Report" and incorporate the findings in developing and evolving their own approaches to restraint of psychiatric patients.

12. That all psychiatric and schedule 1 facilities in Ontario should review CAMH's "Least Restraint Policy" and review their own policies on seclusion and restraint.

13. That although individuals with psychiatric illness may manifest behaviour that puts themselves or others at risk and requires urgent physical intervention, seclusion and restraint should be considered extraordinary interventions.

14. That consideration should be given at all times to alternatives to physical restraint. These alternatives could include low stimulation seclusion rooms and chemical restraint. The chemical restraint will often provide a degree of treatment of the underlying core condition which has given rise to the concerning behaviour. The utilization of these alternative forms would be at the clinical discretion of the treating team.

15. That if a patient's behaviour requiring restraint is a function of an underlying psychiatric condition, that condition should be treated assertively in order to reduce the symptoms of the illness driving the behaviour requiring restraints.

16. That where restraint is applied, it should only be in place for as short a period of time as possible.

17. That all psychiatric and schedule 1 facilities in Ontario should, in the development of their own least restraint policies, seek the views of clients/consumers/survivors representing the client perspective from their own communities.

Quality

18. That all psychiatric and schedule 1 facilities in Ontario should track all episodes of physical restraint of psychiatric patients, and this should be reported and monitored by the organization's Quality Committees, as an important indicator of patient safety. These statistics should be presented to each Hospital's Board on a quarterly basis.

Policy

19. All psychiatric and schedule 1 facilities in Ontario should ensure that policies on restraint contain at a minimum, requirements that:

19.1 Alternative methods and least restrictive care be a priority.
19.2 The client/patient be informed immediately and regularly what is necessary to be released from restraint.
19.3 The person in restraints be reminded of their right to contact with the Patient Advocate (pending revision of the Mental Health Act legislation).
19.4 Staff should provide ongoing support and comfort to the person restrained.
19.5 All staff (including agency staff) should be familiar with policies regarding restraint.
19.6 All clients in restraint ambulate (walk around) for at least 15 minutes every 8 hours where the treating team feels it can be safely accomplished.
19.7 Toileting needs are met.
19.8 Assessments of physical health by clients in physical restraint be performed by an MD in person at least every 24 hours.
19.9 Assessments for release from restraint must be performed by an MD in person at least every 24 hours.
19.10 No order for continuation of restraint can be signed by a person who has not seen the client within two hours.
19.11 External consultation/peer review by an MD not from the unit take place following every 72 hour interval, or sooner.
19.12 Policies and best practices regarding least restrictive care and restraints be followed (e.g. vital signs taken, limbs released).
19.13 One person each shift be assigned the responsibility of ensuring all requirements for the care of the client in restraints are met.
19.14 Has a system to notify the Officer or Person in Charge and/or their designate and the Clinical/Program Director or Unit Manager when a person is restrained.
19.15 Charting reflects what is required of caregivers in relevant policies.

19.16 In event of a death, charting be closed at a time proximate to an individual's death.

20. That all psychiatric and schedule 1 facilities in Ontario should develop a plan for restraint that minimizes the risk for the development of deep vein thrombosis. This plan should consider:

20.1 Early discontinuation of restraint

20.2 Planned intermittent mobilization with ambulatory limb restraints (hand/waist restraints) where feasible, and possible, based on the decision of health care providers. This may require the presence of security.

20.3 A clear description of desired target behaviors, which will allow the client to be released. These should be duly recorded in the client's health record, and provided to the client as soon as physical restraint is initiated.

21. That all psychiatric and schedule 1 facilities in Ontario should ensure that the Person in Charge or the Officer in Charge, and the Unit Manager are notified when a client is placed in restraints.

22. That all psychiatric and schedule 1 facilities in Ontario should ensure that all persons admitted as inpatients for the purpose of receiving psychiatric care, whether voluntary or involuntary, should be requested to provide their choices of management in the event that they decompensate and require physical, chemical or seclusion restraint. This preference should be duly noted in the patient's medical file. This would be consistent with Client-Centred Care.

23. That all psychiatric and schedule 1 facilities in Ontario should ensure that an individual plan of care and treatment be established as soon as is practicable. Every effort should be made to ensure that inpatients have access to meaningful day time activities and therapeutic programming from the time of admission.

24. That all psychiatric and schedule 1 facilities in Ontario should develop a plan with the client based on her/his self identified needs. Unless contraindicated, this plan will include a crisis plan describing:

24.1 Potential emotional triggers and how to address them.

24.2 What works best to help calm the individual if in crisis.

24.3 Options that the client identifies as least restrictive if the person is to be physically contained.

24.4 Whether the individual wants the Patient Advocate contacted if unable to contact them him/herself.

All of the above should be reflected in the client's chart.

25. That all psychiatric and schedule 1 facilities in Ontario should require that where a client/consumer/survivor has been placed in physical restraints, a policy should be created that an external review be undertaken by a psychiatrist who is not part of the treating team. This policy should clearly set out:

25.1 Who is responsible for ensuring that the external review has been completed.

25.2 The mandatory dates and times for when the review must be completed.

25.3 Consideration that this review should occur within 72 hours, or less.

And that the review should be completed by a psychiatrist not associated with the treatment team or the initiating or continuing restraint order.

26. That all psychiatric and schedule 1 facilities in Ontario should create a document which specifies when a client has requested to see a Patient Advocate. This document should specify the time and date that the request was made, and allow for the recording of when the Patient Advocate saw the client.

Education

27. That all psychiatric and schedule 1 facilities in Ontario should consider the client perspective when training health care providers on the implementation of physical restraint. A role should be considered for clients/consumers/survivors and the Psychiatric Patient Advocate Office (PPAO) in assisting in the education of health care staff.

28. That all psychiatric and schedule 1 facilities in Ontario should ensure that members of the treatment team are aware of hospital policies, laws, and provincial guidelines governing restraint and ensure that staff acknowledge this awareness by affixing their signatures to documents prepared for the purposes of education.

29. That all psychiatric and schedule 1 facilities in Ontario should conduct an interdisciplinary review process (“a debrief”) following each and every episode where physical restraint has been utilized in the care of a client. This review should consider whether alternative treatment options were available, whether the length of time in restraint was minimized, and whether the restraint was provided in a manner consistent with written policy.

30. That all psychiatric and schedule 1 facilities in Ontario should invite the PPAO to the debrief where appropriate, and with the consent of the client/consumer/survivor.

31. That all psychiatric and schedule 1 facilities in Ontario should ensure that admitted patients have access to policies regarding restraint and that it is available in a readily understandable form from the time of admission. A member of the health care team should be available to explain the policy and its application when requested.

Nursing

32. That all psychiatric and schedule 1 facilities in Ontario should ensure that where continuous observation is being provided, wherever practicable, it should be done by a small cadre of nurses who would then become familiar with the client and be aware of, and sensitive to, changes in the client's status.

33. That all psychiatric and schedule 1 facilities in Ontario should endeavor to assign a primary nurse and an associate nurse whose duties should be to provide as much of the constant observation of a client in restraint as possible.

34. That all psychiatric and schedule 1 facilities in Ontario should ensure that nursing forms utilized to monitor patients correlate well with written policy.

Physicians

35. That all psychiatric and schedule 1 facilities in Ontario should ensure through policy implementation that all admitted psychiatric patients are provided a full psychiatric assessment by the attending psychiatrist or designate within 24 hours of admission or transfer. Subject to weekends and holidays, this should occur as soon as possible thereafter. To be clear, this should never extend beyond 72 hours.

36. That all psychiatric and schedule 1 facilities in Ontario should ensure that when assigning psychiatrists to new patients on admission and transfer, that the patients should be seen on a weekly basis for the first month and on at least a monthly basis thereafter.

37. All psychiatric and schedule 1 facilities in Ontario should ensure, through policy that upon transfer of a patient, the attending psychiatrist contact the transferring facility, and speak to the sending psychiatrist, for the purpose of identifying any potential de-stabilizers and successful intervention techniques.

38. That all psychiatric and schedule 1 facilities in Ontario should ensure that orders continuing patient restraint are provided every 24 hours, and should only be provided by physicians who have personally examined the client/consumer/survivor.

39. That all psychiatric and schedule 1 facilities in Ontario should ensure that where a client is in physical restraint, the client must be seen by a physician who provides medical care, (as opposed to psychiatric care) to ensure that medical issues that may arise are appropriately attended to every 24 hours.

40. That all psychiatric and schedule 1 facilities in Ontario should require on call physicians to return telephone inquiries from the patient advocate, in respect of patients in restraint, where the issues can not be adequately addressed by the treating team, within 4 hours.

Centre for Forensic Sciences Toxicology Section

41. That the Centre of Forensic Sciences Toxicology Section should, where possible, set detection levels in the therapeutic range for the testing of psychotropic medications. This informs the Coroners Inquest process and does not lead to the erroneous belief that patients were actually not receiving drugs when evidence was provided that they were.

City of Toronto Fire Department (TFD)

42. That the City of Toronto Fire Department should conduct a critical incident review of the management of their involvement with Mr. James around delays in attending, with the assistance of CAMH. This review should consider what policies, if any, were in effect and acted upon. Following this review, the TFD should notify their members of any concerns relating to delays in providing service to Mr. James.

Local Health Integration Networks (LHIN)

43. That all LHINs should require health service providers that deliver psychiatric inpatient services to track episodes of physical restraint as a component of their service accountability agreement. The purpose of this would be to allow the service providers to compile the requisite data to follow an important indicator of psychiatric patient safety.

44. That all LHINs should meet with the PPAO and health service providers within their geographical area to determine the appropriate number (benchmark) of Patient Advocates that would be necessary within the LHIN to provide adequate rights advice and advocacy for clients/consumers/survivors. These numbers should be collectively tabulated and provided to the MINISTRY OF HEALTH AND LONG TERM CARE to allow for planning with respect to fiscal resources allotted annually to the PPAO.

The Ministry of Health and Long Term Care

45. That the Ministry of Health and Long Term Care should mandate that the PPAO have a physical presence (an office) in each of the former provincial psychiatric facilities.

46. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to require the PPAO to provide ***rights advice and advocacy*** for all psychiatric facilities under the Mental Health Act. This should include not just the former provincial psychiatric hospitals, but in addition, all schedule 1 facilities in community and general hospitals where psychiatric care is provided.

47. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to require psychiatric facilities, community and general hospitals operating schedule 1 facilities to notify the PPAO when an inpatient (client/consumer/survivor) receiving care is placed in physical restraints.

48. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to incorporate language that indicates that physical restraint is to be used on a "last resort" basis.[1]

49. That the Ministry of Health and Long Term Care should provide funding to the PPAO to allow it operate with the extended mandate of rights advice and advocacy in all psychiatric facilities including schedule 1 facilities in community and general hospitals where psychiatric care is provided. This funding should contemplate that the PPAO provide service on a 24/7 basis. This funding should be based on a benchmarking exercise conducted by the LHINs, health service providers and the PPAO. (See recommendation # 45)

50. That the Ministry of Health and Long Term Care should provide funding to CAMH for the following:

> " CAMH should take a leadership role with all psychiatric and schedule 1 facilities in Ontario to establish best practices guidelines for restraint, discuss restraint minimization techniques and practices, and collect data regarding incidents of restraint use. This data should be reviewed and compiled annually and presented in a report accessible on line to the public and compliant with the Personal Health Information and Protection of Privacy Act, 2004. CAMH should develop a business plan to be presented to the MINISTRY OF HEALTH AND LONG TERM CARE who should provide sufficient resources for CAMH to conduct this important work, initially, and on a continuing annual basis".

[1] MHA ="restrain" means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient;

51. That the Ministry of Health and Long Term Care should provide financial support to the Registered Nurses' Association of Ontario (RNAO) towards RNAO's development of a nursing Best Practice Guideline (BPG) for the use of restraints in psychiatric patients, and the development of an educational toolkit for nurses.

PPAO

52. That the PPAO should meet with the Ministry of Health and Long Term Care for the purposes of discussing models of governance which allow for sufficient institutional independence and do not contemplate interference by the Ministry with respect to the important duties of rights advice and advocacy provided by the PPAO.

53. That the PPAO should consider governance by a Board of Directors for the purpose of providing oversight and ensuring accountability of the PPAO to clients/consumers/survivors, and ultimately the public, which funds its activities.

54. That the Board of Directors could provide the PPAO with;

54.1 Advice respecting strategic directions, performance expectations, and compelling ethical issues, and

54.2 Direction on operational issues, budgetary planning and approval, making senior personnel decisions, and establishing a complaints process.

55. That the Board should have a membership consisting of competent members from institutions and organizations who are familiar with, and have expertise, acting in the public domain. The majority of these members should be drawn from the consumer/survivor community and further include advocate groups such as the Empowerment Council.

56. That following establishment of a Board of Directors for governance, the PPAO should undergo a strategic planning process which re-evaluates its mandate. This process should seek to evolve from its current mandate, established in the early 1980s, to a contemporary one. As a component of its strategic planning process, the PPAO should invite stakeholders such as the Empowerment Council, CAMH, representatives from LHINs, representatives from schedule 1 facilities, and others to advise and inform their process.

57. That as a component of its strategic planning process, the PPAO should seek to review and revise its model of service delivery.

58. That the model of service delivery, should consider, as a minimum:
    58.1 That the needs of clients/consumers/survivors are required 24/7. The current availability is Monday to Friday from 9 am to 5 pm.
    58.2 How long a Patient Advocate (PA) should take to respond to the requests of clients/consumers/survivors for a meeting, effectively creating a triaging system based on the situation and intensity of need. For example, physical restraint should be considered a critical incident requiring immediate attention.
    58.3 With the consent of the client/consumer/survivor, a review of the medical file to inform the PA should occur. This would ensure that the PA would advocate most effectively on behalf of the client and address the clinical team with a more fully informed assessment of the issues.
    58.4 The method and timeliness of recording client/consumer/survivor encounters. These should be entered into the logging system immediately following any interviews, and always contemporaneously, as is done by health care providers.
    58.5 Where notes are taken by PAs, they should be kept until resolution of the situation, and where death occurs, they should be kept indefinitely.
    58.6 A document should be created which allows the PA to record clients' wishes, and this should be presented to the health care team following verbal communication.

59. That the PPAO should develop a training program to educate its advocates regarding the reasons why persons are placed in restraints, including indication for restraint, risks and benefits.

Ontario Review Board (ORB)

60. That the Ontario Review Board should convene a Restriction of Liberties Hearing within 4 days upon notice by facilities whenever a person under ORB jurisdiction has been mechanically restrained for 7 days.

Registered Nurses' Association of Ontario(RNAO)

61. That the RNAO should develop a nursing best practice guideline for the use of restraints in psychiatric patients, in consultation with relevant stakeholders such as the Ontario Nurses' Association.

62. That the best practice guideline should be provided to nurses with the use of a toolkit.

63. That this education should be supported by all psychiatric and schedule 1 facilities and should include the nursing clinical educator of the unit providing a lecture on the risks and benefits of restraint with the following characteristics:

63.1 Education should begin immediately upon completion of the BPG.

63.2 The education should be provided in each facility.

63.3 It should be targeted to the nursing staff and discuss the risks of pulmonary embolism.

63.4 It should be repeated biannually.

The Office of the Chief Coroner (OCC)

64. That the Office of the Chief Coroner should conduct inquests into the deaths of psychiatric patients being cared for in psychiatric and schedule 1 facilities who die while being subjected to physical (mechanical) restraints. For clarity, this does not necessarily include those who die while under seclusion or chemical restraint, or while involuntarily admitted to these facilities unless they are in physical restraints. This policy is not intended to be retrospective, and should include deaths in which physical restraint was involved beginning October 10, 2008.

65. That the OCC should provide all psychiatric and schedule 1 facilities with a copy of the Jury's Verdict and Recommendations and the Coroner's Verdict Explanation.

66. That the OCC will provide a report to any interested parties with respect to the recommendations within one year of the Inquest being completed, upon request.

VERDICT EXPLANATION

Inquest into the Death of

Jeffrey James

September 15 to October 10, 2008
Coroners Courts
15 Grosvenor Street
Toronto, Ontario

Opening Comment

I intend to give a brief synopsis of the 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 of this is to assist the reader to more fully understand the verdict and the recommendations of the Jury and it 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. Michael Blain Office of the Chief Coroner 26 Grenville St. Toronto, ON M7A 2G9 416-314-0468
Investigating Officer	Detective Marcel Chiasson Toronto Police Service 14 Division Criminal Investigation Branch 150 Harrison St. Toronto, ON M6J 2A4 416-808-1404
Coroner's Constable	Detective Sergeant John Rowett Detective Constable Jim Swick Toronto Inquest Courts 15 Grosvenor Ave. Toronto, ON M7A 2G9 416-314-4000
Court Reporter	Ms. Ala Kleinberg Network Reporting and Mediation

	One First Canadian Place 100 King St. West, Suite 3210 Toronto, ON M5X-1E3 416-359-0305
Parties with Standing	**Represented by**
1. Registered Nurses Association of Ontario	Ms. Adrienne Liang Mr. David Wright Mr. Tim Hannioan Ryder Wright Blair and Holmes LLP 333 Adelaide St. West, 3rd Floor Toronto, ON M5V 1R5 416-340-9070
2. Empowerment Council	Ms. Anita Szigeti Hiltz and Szigeti LLP 94 Cumberland Street Suite 906 Toronto, ON M5R 1A3 416-504-6575
3. Psychiatric Patient Advocate Office Ms. A. Martin	Mr. Ryan Fritsch 55 St. Clair Avenue West Box 28, Suite 802, Toronto, ON M4V 2Y7 416-327-7002
4. Nurses Ms. V. Mag-Ibe, Mr. B. Richards Mr. R. English	Mr. Robert K. Stephenson Stephenson and Stephenson, LLP 181 University Avenue, Suite 1812 Toronto, ON M5H 3M7 416-594-1331
5. Physicians Dr. M. Sui, Dr. P. Darby, and Dr. M. Weisbrod	Mr. Eli Lederman Ms. Yashoda Ranganathan Lenczner Slaght Royce Smith Griffen LLP Suite 2600, 130 Adelaide Street West, Toronto, ON M5H 3P5 416-865-9500

6. Centre for Addiction and Mental Health Dr. Barbaree, Mr. D. Ferguson, Ms. June Lawrence, Mr. J. Oteng, Ms. S. Pullan, Mr. R. Rashid, Ms. M. Seth Ms. S. Reyes	Ms. Tanya Goldberg Mr. Patrick Hawkins Borden Ladner Gervais Scotia Plaza, 40 King Street West, Toronto, ON M5H 3Y4 416-367-6002

Summary of the Circumstances

Jeffrey James aged 34 died at the Toronto Western Hospital, University Health Network, on July 13, 2005 at 1718 hours. This occurred following his transport from the Centre for Addiction and Mental Health (CAMH) where he had collapsed after his release from 5 days of physical (mechanical) restraint.

Mr. James had a long history of a serious criminal record that included violent sexual offences. He had acquired 49 entries with police, including 16 criminal convictions, 7 for violent offences. His index offence occurred on March 14, 2004. At that time, he approached an adult female in a mall, to whom he exposed himself sexually, and with whom he attempted to force oral genital contact. Security arrived and he fled the scene, eventually getting into a cab where he began to assault the driver. He was subsequently apprehended.

Mr. James suffered with schizophrenia, and had been receiving psychiatric care on an outpatient basis. He suffered with delusional thoughts that a “world army” would harm him unless he played a game. The game consisted of Mr. James obtaining sexual favours from a person, and if he was unsuccessful, he would come to harm. This delusion appeared to be a driver for his behavior.

On January 6, 2005, he was found not criminally responsible on charges of sexual assault, assault, breach of probation, breach of recognizance and assaulting a peace officer. No disposition was made by the trial judge and he was remanded in custody to the Penetanguishene Mental Health Centre pending a hearing by the Ontario Review Board. There, he was found to be aggressive, violent and sexually inappropriate. Following treatment, he improved and ultimately, despite some initial reservations by his treating physician, he was transferred to a medium security all male ward at CAMH. This transfer occurred on May 20th, 2005. At CAMH, he was placed on ward 3-2, a 20 bed all male unit in the Law and Mental Health Program. The unit had a secure perimeter, with a double lock door system to enter the unit, cameras throughout and it was staffed at higher levels. It also had 2 seclusion rooms.

He was seen by a medical physician on the day of his transfer. He was first seen by his attending psychiatrist on June 18, 2005. He was deemed “capable” for matters of consent with regard to treatment. On June 30th, a team review of his management was undertaken.

On July 8th, 2005, he was noted to be masturbating at a nursing station. He was directed to his room. When he did not respond, attempts were made by male nurses to direct him to a seclusion room. He violently resisted, a “Code White” was initiated, and he was ultimately subdued by a combination of health care providers numbering approximately 8 in total. Those that participated in subduing Mr. James described the event as amongst the most physically draining episodes in which they had been involved. Mr. James was a man of large stature and reported strength. He was ultimately placed in a seclusion room in 4 point restraint. These rooms are locked isolation rooms in which clients are placed, while being constantly (24/7) observed by a nurse who can view the client through a two way mirror. The restraint system consisted of utilization of a device which tethered each of his arms and legs to a bed. The limb restraints could be individually lengthened or shortened and this feature would be utilized depending on the cooperation and behavior of the client. To address his behavior on July 8, 2005, he was;

- placed in a seclusion room on constant observation,
- 4-point mechanical (physical) restraint, and
- provided with chemical restraint in the form of medication.

He was constantly monitored by nursing staff throughout his stay. His physical restraints were re-ordered each day by a physician. He was, however, not seen by a physician each day.

On July 11th at 1520 hours, the Psychiatric Patient Advocate Office located at CAMH was notified that Mr. James was requesting to speak to a patient advocate. The PA received the message from a colleague at 1609 hours. The Psychiatric Patient Advocate Office is an “arms length” section of the Ministry of Health and Long Term Care (MOHLTC) which provides confidential and independent advocacy for consumers of psychiatric care. The Patient Advocate (PA) met with Mr. James promptly, and as a “voice for the client” spoke to nursing staff regarding his expressed concerns. These concerns included his meals, getting up to bathe, and cessation of his restraint. He remained preoccupied sexually and was aggressive which precluded his release. On July 12th, the PA again met with Mr. James, spoke to nursing staff, and left a message for Mr. James’s attending psychiatrist.

On July 13th, the PA again conveyed concerns regarding Mr. James and cessation of his restraints. The nursing team did note that although he still manifested some features of his delusional thinking, he had improved to the point that he would follow direction. A team decision was made that Mr. James would be released from restraints for the purposes of having a shower. His attending psychiatrist was consulted by telephone and was agreeable.

Mr. James was released from physical restraints, and he was required to sit at the side of the bed for 5 minutes. He was gradually mobilized out of the seclusion

room down a hallway leading to the shower. After walking 15-20 steps, he reported dizziness and weak legs. He was gently lowered to the floor, and became unresponsive. He briefly gained consciousness again, and then lapsed into cardiopulmonary arrest, and a “Code Blue” medical emergency was initiated. Ultimately, he was transferred to the emergency department of the Toronto Western Hospital, University Health Network where he was pronounced deceased at 1718 hours, July 13, 2005.

A post mortem examination was performed on July 14, 2005. It found the cause of death to be “Acute Pulmonary Thromboembolism in a Man with Medical Restraint”.

A discretionary inquest was conducted at the Coroners Courts pursuant to Section 20 of the Coroners Act, which states:

What coroner shall consider and have regard to

20. When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider,

(a) whether the matters described in clauses 31 (1) (a) to (e) are known;

(b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and

(c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances. R.S.O. 1990, c. C.37, s. 20.

Twenty-one witnesses gave evidence over twelve days, and twenty-eight items were entered as exhibits. The Jury deliberated for approximately 12 hours over two days to arrive at its verdict.

Verdict

1. Name of Deceased:	Jeffrey James
2. Date and Time of Death:	July 13, 2005 at 1718 hours
3. Place of Death:	Toronto Western Hospital, Toronto, Ontario

4. Cause of Death:	acute pulmonary thromboembolism in a man with medical restraint
5. By What Means:	Natural

Recommendations of the Jury

Coroner's Initial Comments

The reader is cautioned that the following recommendations are provided by the Jury, and should be considered unique to the factual circumstances of Mr. James's death. At the time of his death, he was in inpatient of a psychiatric facility and following psychiatric decompensation, he was treated with seclusion, mechanical (physical) and chemical restraint.

Although patients/consumers/survivors that decompensate while in the community and are brought to hospital emergency departments for care and admission were briefly discussed in evidence at the inquest, their situation is different then that of Mr. James. As such, the recommendations proffered by the Jury are not necessarily applicable to other subsets of patients/consumers/survivors.

The definition of restraint was provided to the Inquest from the *Mental Health Act.* Restrain means "place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient".

The following legend is offered to assist the reader to navigate the recommendations.

Legend

CAMH=	Centre for Addiction and Mental Health
Client=	Patient=Consumer/Survivor
EC=	Empowerment Council
MOHLTC=	Ministry of Health and Long Term Care
PA=	Patient Advocate
PPAO=	Psychiatric Patient Advocate Office
RNAO=	Registered Nurses' Association of Ontario

Accreditation Canada (formerly Canadian Council on Health Services Accreditation CCHSA)

Recommendation #1

1. That Accreditation Canada should set as a standard for accreditation, a required organizational practice that health care facilities providing psychiatric care should develop reporting mechanisms and practices that track all incidents of physical restraint involving psychiatric patients. This could fall under the auspices of "Required Organizational Practices, Patient Safety, Risk Assessment".

Coroner's Comments
The President of the Registered Nurses' Association of Ontario gave evidence that tracking incidents of physical restraint could be accomplished by requesting that Accreditation Canada require health care facilities to track such events as a required organizational practice under the auspices of patient safety.

Centre for Addiction and Mental Health (CAMH)

Recommendation #2

2. That CAMH continue to aspire to provide care to clients/consumers/survivors in a restraint free environment.

Coroner's Comments
The Clinical Director of the Law and Mental Health Program gave evidence that the death of Mr. James and another client during physical restraint had a profound effect on CAMH, and caused them to re-evaluate their use of restraints. Organizationally, they now aspire to be restraint free.

Recommendation #3

3. That consistent with its leadership role, CAMH should share with all psychiatric and schedule 1 facilities in Ontario, its:

3.1 Restraint Minimization Task Force May 30th, 2008 Final Report.
3.2 Bill of Client Rights.
3.3 Least Restraint Policy.

Coroner's Comments
Following the death of Mr. James, CAMH struck a task force to review its approach to the utilization of restraint. The task force reviewed best practice models in North America, and has issued its final report. Evidence was heard that this document, as well as its *Bill of Client Rights* and its *Least Restraint*

Policy are contemporary, and reflect consultation with consumers/survivors of psychiatric services. Opportunities may exist for other psychiatric and schedule 1 facilities in Ontario to benefit from CAMH's leadership and approach with respect to client centred care.

Recommendation #4

4. That CAMH should take a leadership role with all psychiatric and schedule 1 facilities in Ontario to:

4.1 Establish best practices guidelines for restraint.
4.2 Discuss restraint minimization techniques and practices.
4.3 Develop a data collection system regarding incidents of restraint use.

This data should be reviewed and compiled annually and presented in a report accessible to the public on line and be compliant with the Personal Health Information and Protection of Privacy Act, 2004. That CAMH should develop a business plan to be presented to the Ministry of Health and Long Term Care who should provide sufficient funding for CAMH to conduct this important work.

Coroner's Comments

Evidence was heard that the Law and Mental Health Program had decreased its utilization of physical restraint from 14 episodes in 2005/6, to 8 episodes in 2006/7 to 1 episode in 2007/8. This largely occurred as a result of a commitment to change its approach, reliably gather data on restraint and provide this to the Executive Leadership Team. Evidence was provided that:
"CAMH's commitment to client-centred, recovery-oriented, holistic care and the safe provision of therapeutic mental health treatment and care underpins the desire to not only improve, by way of significant restraint reduction at CAMH but, in the long run, to provide leadership to other facilities and contribute to a significant restraint reduction throughout the province".

Recommendation #5

5. That CAMH should redesign all forms related to the charting of patients in restraint to reduce complexity and ensure compliance with written policy, in order to ensure that all aspects of written policy are carried out.

Coroner's Comments

An expert opinion from a forensic psychiatrist was obtained regarding the care provided to Mr. James. His opinion was that nursing forms utilized to ensure compliance with written policy could benefit from simplification and revision.

Recommendation #6

6. That CAMH should ensure that counseling and emotional supports are made available to patients on a unit following the death of a client/consumer/survivor.

Coroner's Comments
This is self-explanatory. Deaths of clients in psychiatric care are rare events, and formalized programs to administer to the needs of other surviving clients should such an event occur may be of benefit.

Recommendation #7

7. That CAMH should ensure that all health service providers are provided mandatory in-service education on the minimization of restraints, the use of restraints, and the medical risks associated with restraints including pulmonary embolism.

Coroner's Comments
Evidence was heard that physical restraint, which causes immobilization, leads to stasis of the blood, which can lead to deep vein thrombosis and pulmonary embolism. Two experts, one in forensic pathology and the other in thromboembolism had done literature searches and found that there were but a few cases of psychiatric patients in physical restraint who suffered pulmonary embolism reported in the world literature. This knowledge must be disseminated to health care providers.

Recommendation #8

8. That CAMH should ensure that all health service providers are provided with in-service education with respect to the Jury's Verdict and Recommendations.

Coroner's Comments
This is self-explanatory.

Psychiatric and Schedule 1 Facilities

Guiding Principles

Recommendation #9

9. That all psychiatric and schedule 1 facilities in Ontario should aspire to provide care to clients/consumers/survivors in restraint free environments.

Coroner's Comments
Evidence was heard from an expert forensic psychiatrist that as a guiding principle, all organizations providing psychiatric care should aspire to be restraint free.

Recommendation #10

10. That all psychiatric and schedule 1 facilities in Ontario should review the CAMH's *Bill of Client Rights*. In facilities where a Bill of Client Rights does not exist, one should be created and modeled after CAMH's *Bill of Client Rights*.

Coroner's Comments
Evidence was heard from both administrators at CAMH and the Empowerment Council who are consumer/survivors and clients of CAMH about the development of CAMH's *Bill of Client Rights*. This document had input from patients who utilize services at CAMH, which could be a guiding principle for all psychiatric facilities providing care to psychiatric patients.

Recommendation #11

11. That all psychiatric and schedule 1 facilities in Ontario should review the CAMH's, "Restraint Minimization Task Force May 30th, 2008 Final Report" and incorporate the findings in developing and evolving their own approaches to restraint of psychiatric patients.

Coroner's Comments
Evidence was heard about the development of this document, which was carefully and with great effort, informed by other North American jurisdictions, some of which had evolved to become restraint free. Other organizations could learn from CAMH's research and conclusions.

Recommendation #12

12. That all psychiatric and schedule 1 facilities in Ontario should review CAMH's "*Least Restraint Policy*" and review their own policies on seclusion and restraint.

Coroner's Comments
The evolution of CAMH's *Least Restraint Policy* and its latest iteration will be informed by the results of the Restraint Minimization Task Force.

Recommendation #13

13. That although individuals with psychiatric illness may manifest behavior that puts themselves or others at risk and requires urgent physical intervention, seclusion and restraint should be considered extraordinary interventions.

Coroner's Comments
Evidence supporting this was notionally provided by many witnesses at the inquest. The Ontario Nurse's Association, (ONA) has developed guidelines for the utilization of restraint which promulgates this concept.

Recommendation #14

14. That consideration should be given at all times to alternatives to physical restraint. These alternatives could include low stimulation seclusion rooms and chemical restraint. The chemical restraint will often provide a degree of treatment of the underlying core condition which has given rise to the concerning behavior. The utilization of these alternative forms would be at the clinical discretion of the treating team.

Recommendation #15

15. That if a patient's behaviour requiring restraint is a function of an underlying psychiatric condition, that condition should be treated assertively in order to reduce the symptoms of the illness driving the behaviour requiring restraints.

Coroner's Comments for #14 and #15

An expert in forensic psychiatry gave evidence that physical restraint was the most intrusive form of restraint. In addition, he stated that psychosis and violent behaviour are linked. Medications, which are chemical restraints will therefore not only treat the concerning behaviour, but also, can provide some treatment for the underlying psychiatric illness whose delusions or hallucinations can be drivers for aberrant behaviour. Seclusion restraint, in which clients are placed in low stimulation rooms and observed, is a "hands off" means of providing restraint, which is preferred to physical restraint.

Recommendation #16

16. That where restraint is applied, it should only be in place for as short a period of time as possible.

Coroner's Comments

This is self-explanatory. An expert in thromboembolism gave evidence that by mobilizing individuals as soon as possible following implementation of physical restraint, the risk of deep vein thrombosis and pulmonary embolism could be minimized.

Recommendation #17

17. That all psychiatric and schedule 1 facilities in Ontario should, in the development of their own least restraint policies, seek the views of clients/consumers/survivors representing the client perspective from their own communities.

Coroner's Comments
Evidence was heard from a consumer/survivor witness regarding this matter. This is a best practice model which aspires to embrace the concept of "client-centred" care.

Quality

Recommendation #18

18. That all psychiatric and schedule 1 facilities in Ontario should track all episodes of physical restraint of psychiatric patients, and this should be reported and monitored by the organization's Quality Committees, as an important indicator of patient safety. These statistics should be presented to each Hospital's Board on a quarterly basis.

Coroner's Comments
Evidence was heard from a number of witnesses regarding the seriousness of physical restraint, and the necessity of tracking episodes and providing this data to the highest level of decision making capacity within an organization. This is an important matter of patient safety and should therefore be at the forefront of organizational consciousness.

Policy

Recommendation #19

19. All psychiatric and schedule 1 facilities in Ontario should ensure that policies on restraint contain at a minimum, requirements that:

19.1 Alternative methods and least restrictive care be a priority.
19.2 The client/patient be informed immediately and regularly what is necessary to be released from restraint.
19.3 The person in restraints be reminded of their right to contact with the Patient Advocate (pending revision of the Mental Health Act legislation).
19.4 Staff should provide ongoing support and comfort to the person restrained.
19.5 All staff (including agency staff) should be familiar with policies regarding restraint.
19.6 All clients in restraint ambulate (walk around) for at least 15 minutes every 8 hours where the treating team feels it can be safely accomplished.
19.7 Toileting needs are met.
19.8 Assessments of physical health by clients in physical restraint be performed by an MD in person at least every 24 hours.
19.9 Assessments for release from restraint must be performed by an MD in person at least every 24 hours.
19.10 No order for continuation of restraint can be signed by a person who has not seen the client within two hours.

19.11 External consultation/peer review by an MD not from the unit take place following every 72 hour interval, or sooner.
19.12 Policies and best practices regarding least restrictive care and restraints be followed (e.g. vital signs taken, limbs released).
19.13 One person each shift be assigned the responsibility of ensuring all requirements for the care of the client in restraints are met.
19.14 Has a system to notify the Officer or Person in Charge and/or their designate and the Clinical/Program Director or Unit Manager when a person is restrained.
19.15 Charting reflects what is required of caregivers in relevant policies.
19.16 In event of a death, charting be closed at a time proximate to an individual's death.

Coroner's Comments

This recommendation encompasses 16 components which came to light through many different witnesses. Some of these arise from recognized opportunities for improvement in the management of patients in physical restraint, whereas others arise from opinion evidence proffered as best practice.

Recommendation #20

20. That all psychiatric and schedule 1 facilities in Ontario should develop a plan for restraint that minimizes the risk for the development of deep vein thrombosis. This plan should consider:

20.1 Early discontinuation of restraint.

20.2 Planned intermittent mobilization with ambulatory limb restraints (hand/waist restraints) where feasible, and possible, based on the decision of health care providers. This may require the presence of security.

20.3 A clear description of desired target behaviours, which will allow the client to be released. These should be duly recorded in the client's health record, and provided to the client as soon as physical restraint is initiated.

Coroner's Comments

An expert in thromboembolism stated that early discontinuation of restraint with mobilization of the client were the most effective means of preventing deep vein thrombosis and pulmonary embolism. Loosening of 4 point limb restraints does not allow compression of the deep veins of the legs by muscles and prevention of venous stasis. In addition, prophylactic measures such as antiembolic stockings and chemoprophylaxis with anticoagulants are not recommended. Physical restraints have been developed that allow a client to be mobilized while ensuring that the upper limbs remain firmly affixed to a waist restraint, thereby limiting the opportunity for incurring injury to health care providers.

In addition, evidence was heard that clients need to understand what behaviour is necessary to obtain release from restraint.

Recommendation #21

21. That all psychiatric and schedule 1 facilities in Ontario should ensure that the Person in Charge or the Officer in Charge, and the Unit Manager are notified when a client is placed in restraints.

Coroner's Comments

An expert in forensic psychiatry gave evidence that "Seclusion and Restraint should be considered extraordinary interventions". Evidence suggested that by necessity, it should therefore require that persons in authority for the operational management of psychiatric facilities be notified when such an event occurs.

Recommendation #22

22. That all psychiatric and schedule 1 facilities in Ontario should ensure that all persons admitted as inpatients for the purpose of receiving psychiatric care, whether voluntary or involuntary, should be requested to provide their choices of management in the event that they decompensate and require physical, chemical or seclusion restraint. This preference should be duly noted in the patient's medical file. This would be consistent with Client-Centred Care.

Coroner's Comments

The Coordinator of the Empowerment Council gave evidence that the *Bill of Client Rights* was a collaboration between CAMH and its clients. She described it as the best bill of its kind in Canada. It was developed to assert and promote the dignity and worth of all of the people who use the services of CAMH. Right #7 is entitled *The Right to Make Informed Choice and Give Informed Consent to Treatment.* Right #7 also states that "Every client has the right to have his/her prior capable wishes respected to the fullest extent that the law allows". This was supported by an expert forensic psychiatrist.

Recommendation #23

23. That all psychiatric and schedule 1 facilities in Ontario should ensure that an individual plan of care and treatment be established as soon as is practicable. Every effort should be made to ensure that inpatients have access to meaningful day time activities and therapeutic programming from the time of admission.

Coroner's Comments

The CAMH Restraint Minimization Task Force completed its report in May of 2008. Site visits were performed by CAMH to mental health inpatient services that reported a significant reduction in restraint use. The report noted that "client programming was a notable component of client care and a significant aspect/strategy in the prevention and management of aggressive behaviour". In addition to its therapeutic benefits, "…such programming was seen as an important component in reducing the use of restraint and seclusion". Mr. James

was admitted to CAMH on May 20th. He was first seen by his psychiatrist on June 18, 2008. Programming was somewhat delayed by the extended period to psychiatric assessment.

Recommendation #24

24. That all psychiatric and schedule 1 facilities in Ontario should develop a plan with the client based on her/his self identified needs. Unless contraindicated, this plan will include a crisis plan describing:

24.1 Potential emotional triggers and how to address them.
24.2 What works best to help calm the individual if in crisis.
24.3 Options that the client identifies as least restrictive if the person is to be physically contained.
24.4 Whether the individual wants the Patient Advocate contacted if unable to contact them him/herself.

All of the above should be reflected in the client's chart.

Coroner's Comments

The Coordinator of the Empowerment Council gave evidence the clients/consumers/survivors will have self-identified needs. Right #7 in the CAMH *Bill of Client Rights* is entitled *The Right to Make Informed Choice and Give Informed Consent to Treatment.* Client centred care embraces the concept of engaging the client in decision making, and should be considered a best practice model of service delivery.

Recommendation #25

25. That all psychiatric and schedule 1 facilities in Ontario should require that where a client/consumer/survivor has been placed in physical restraints, a policy should be created that an external review be undertaken by a psychiatrist who is not part of the treating team. This policy should clearly set out:

25.1 Who is responsible for ensuring that the external review has been completed.
25.2 The mandatory dates and times for when the review must be completed.
25.3 Consideration that this review should occur within 72 hours, or less.

and that the review should be completed by a psychiatrist not associated with the treatment team or the initiating or continuing restraint order.

Coroner's Comments

CAMH's *Least Restraint Policy* mandated that "An external consultation should be completed every 72 hours that a client/patient remains continuously in restraint". Mr. James was restrained for approximately 5.5 days. This external consultation did not occur. The purpose of the external consultant providing this review is to provide an independent look at the treating team's management strategies, and determine whether opportunities for care exist that had not been contemplated.

Recommendation #26

26. That all psychiatric and schedule 1 facilities in Ontario should create a document which specifies when a client has requested to see a Patient Advocate. This document should specify the time and date that the request was made, and allow for the recording of when the Patient Advocate saw the client.

Coroner's Comments
Involvement of the Patient Advocate with Mr. James may have served as a catalyst to draw the attention of the treating team to release him from restraints on the day of his death. The Patient Advocate may serve as the voice of the client, when clients are incapacitated and unable to adequately express themselves.

Education

Recommendation #27

27. That all psychiatric and schedule 1 facilities in Ontario should consider the client perspective when training health care providers on the implementation of physical restraint. A role should be considered for clients/consumers/survivors and the Psychiatric Patient Advocate Office (PPAO) in assisting in the education of health care staff.

Coroner's Comments
The importance of the client/consumer/survivor perspective and the need for health care providers to understand that perspective was provided by the Coordinator of the Empowerment Council.

Recommendation #28

28. That all psychiatric and schedule 1 facilities in Ontario should ensure that members of the treatment team are aware of hospital policies, laws, and provincial guidelines governing restraint and ensure that staff acknowledge this awareness by affixing their signatures to documents prepared for the purposes of education.

Coroner's Comments
This is self-explanatory. Evidenced was heard that hospitals frequently utilize agency nurses to assist when they are short of their own staff. CAMH's practice was to ensure that all agency nurses had undergone an appropriate orientation before working in the Law and Mental Health Program.

Recommendation #29

29. That all psychiatric and schedule 1 facilities in Ontario should conduct an interdisciplinary review process ("a debrief") following each and every episode

where physical restraint has been utilized in the care of a client. This review should consider whether alternative treatment options were available, whether the length of time in restraint was minimized, and whether the restraint was provided in a manner consistent with written policy.

Coroner's Comments

This is a quality assurance practice around an event which should be considered as a critical incident and an extraordinary measure. Opportunities to learn and self-reflect from these events needs to be maximized in the interests of continuous improvement and minimizing their recurrence.

Recommendation #30

30. That all psychiatric and schedule 1 facilities in Ontario should invite the PPAO to the debrief where appropriate, and with the consent of the client/consumer/survivor.

Coroner's Comments

The PPAO is mandated to;

- Advance the legal and civil rights of psychiatric patients through individual case work and systemic advocacy.
- Inform patients, their families, hospital staff and the community about the legal and civil rights of mental health consumers through public education and training.
- Resolve complaints made by psychiatric patients by providing avenues for resolution through negotiation according to patients instructions and to assist individuals to advocate on their own behalf.
- Investigate alleged incidents, including incidents of abuse, and to assess institutional and systemic responses to these incidents.
- Provides rights advice.

Given the mandate of the PPAO, they are ideally suited to assist in the debrief provided consent has been given by the client/consumer/survivor, and the psychiatric and schedule 1 facility feels it would be appropriate.

Recommendation #31

31. That all psychiatric and schedule 1 facilities in Ontario should ensure that admitted patients have access to policies regarding restraint and that it is available in a readily understandable form from the time of admission. A member of the health care team should be available to explain the policy and its application when requested.

Coroner's Comments

This is a component of the CAMH *Bill of Client Rights.* Right #5, is the *Right to Effective Communication.* It states that "Every client has the right to effective communication in a form, language, and manner that assists the client to understand the information provided". Other facilities are being encouraged to embrace this approach.

Nursing

Recommendation #32

32. That all psychiatric and schedule 1 facilities in Ontario should ensure that where continuous observation is being provided, wherever practicable, it should be done by a small cadre of nurses who would then become familiar with the client and be aware of, and sensitive to, changes in the client's status.

Recommendation #33

33. That all psychiatric and schedule 1 facilities in Ontario should endeavor to assign a primary nurse and an associate nurse whose duties should be to provide as much of the constant observation of a client in restraint as possible.

Coroner's Comments for #32 and #33

The practice of CAMH was to provide continuous observation of a client in restraint by nurses rotating every two hours. During Mr. James 5.5 day period of restraint, approximately 40 different nurses conducted continuous observation on him. The opportunity to observe and appreciate subtle changes in a client's status could potentially be maximized by a small group of nurses who would then become very familiar with a client.

Recommendation #34

34. That all psychiatric and schedule 1 facilities in Ontario should ensure that nursing forms utilized to monitor patients correlate well with written policy.

Coroner's Comments

There are a number of nursing practices and observations required in the care of patients in physical restraint. For instance, frequent vital signs, repositioning, checking circulation and skin, as well as input and output are required. The expert forensic psychiatrist that provided an opinion with respect to Mr. James noted "The forms used to document nursing interactions do not necessarily correlate closely with the policy and one may need to make some assumptions (or not) about whether they were able to follow the policy".

Physicians

Recommendation #35

35. That all psychiatric and schedule 1 facilities in Ontario should ensure through policy implementation that all admitted psychiatric patients are provided a full psychiatric assessment by the attending psychiatrist or designate within 24 hours

of admission or transfer. Subject to weekends and holidays, this should occur as soon as possible thereafter. To be clear, this should never extend beyond 72 hours.

Coroner's Comments

Mr. James was admitted on May 20, 2008 and was assessed by his attending psychiatrist on June 18, 2008. This occurred as his attending psychiatrist was on vacation. In evidence, this psychiatrist agreed that the delay was "extreme", and further, that ideally; a new client should be seen on the day that they arrive.

Recommendation #36

36. That all psychiatric and schedule 1 facilities in Ontario should ensure that when assigning psychiatrists to new patients on admission and transfer, that the patients should be seen on a weekly basis for the first month and on at least a monthly basis thereafter.

Coroner's Comments

During his 54 day admission, Mr. James was seen by his attending psychiatrist 5 times. Three of those occasions occurred when he was in restraint in the 5 days prior to his death.

Recommendation #37

37. All psychiatric and schedule 1 facilities in Ontario should ensure, through policy that upon transfer of a patient, the attending psychiatrist contact the transferring facility, and speak to the sending psychiatrist, for the purpose of identifying any potential de-stabilizers and successful intervention techniques.

Coroner's Comments

Upon his admission to Penetanguishene Mental Health Centre pending a hearing by the Ontario Review Board, Mr. James was found to be aggressive, violent and sexually inappropriate. Following treatment, he improved. Upon admission to CAMH, he was noted to be compliant and no difficulties were noted. He decompensated on July 8th, and was placed in restraints following a violent struggle. As a best practice opportunity in care, a conversation between the receiving psychiatrist and the sending psychiatrist could allow for the seamless transfer of information in the interests of the patient's care.

Recommendation #38

38. That all psychiatric and schedule 1 facilities in Ontario should ensure that orders continuing patient restraint are provided every 24 hours, and should only be provided by physicians who have personally examined the client/consumer/survivor.

Recommendation #39

39. That all psychiatric and schedule 1 facilities in Ontario should ensure that where a client is in physical restraint, the client must be seen by a physician who provides medical care, (as opposed to psychiatric care) to ensure that medical issues that may arise are appropriately attended to every 24 hours.

Coroner's Comments to #38 and #39
These recommendations are self-explanatory. Recommendation #38 directs a physician not to rely upon nursing observations when re-ordering restraints but rather, it requires the physician to personally examine the patient.

Recommendation #40

40. That all psychiatric and schedule 1 facilities in Ontario should require on call physicians to return telephone inquiries from the patient advocate, in respect of patients in restraint, where the issues can not be adequately addressed by the treating team, within 4 hours.

Coroner's Comments
A Patient Advocate had attempted to contact Mr. James's attending psychiatrist, but he did not respond. This recommendation is directed solely to the rare and unique circumstance where a patient is in restraints.

Centre for Forensic Sciences Toxicology Section

Recommendation #41

41. That the Centre of Forensic Sciences Toxicology Section should, where possible, set detection levels in the therapeutic range for the testing of psychotropic medications. This informs the Coroners Inquest process and does not lead to the erroneous belief that patients were actually not receiving drugs when evidence was provided that they were.

Coroner's Comments
Mr. James had been treated with psychotropic medications for his illness. At the time of his autopsy, blood levels for drugs he was known to have received were reported as "not detected". A toxicologist gave evidence that the limit of detection was set above the therapeutic range for these drugs, and that they may well have been present.

City of Toronto Fire Department (TFD)

Recommendation #42

42. That the City of Toronto Fire Department should conduct a critical incident review of the management of their involvement with Mr. James around delays in

attending, with the assistance of CAMH. This review should consider what policies, if any, were in effect and acted upon. Following this review, the TFD should notify their members of any concerns relating to delays in providing service to Mr. James.

Coroner's Comments

Evidence was given by a security officer at CAMH that members of the Fire Department delayed entering CAMH and attending on unit 3-2 when informed that it was the Law and Mental Health Unit. There may have been some misapprehension about personal safety.

Local Health Integration Networks (LHIN)

Recommendation #43

43. That all LHINs should require health service providers that deliver psychiatric inpatient services to track episodes of physical restraint as a component of their service accountability agreement. The purpose of this would be to allow the service providers to compile the requisite data to follow an important indicator of psychiatric patient safety.

Coroner's Comments

The purpose of the Local Health System Integration Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province.[1] The tracking of episodes of physical restraint could be a component of the accountability agreement in respect of the provision of psychiatric services between providers and the LHINs. This could provide an important indicator of psychiatric patient safety.

Recommendation #44

44. That all LHINs should meet with the PPAO and health service providers within their geographical area to determine the appropriate number (benchmark) of Patient Advocates that would be necessary within the LHIN to provide adequate rights advice and advocacy for clients/consumers/survivors. These numbers should be collectively tabulated and provided to the MINISTRY OF HEALTH AND LONG TERM CARE to allow for planning with respect to fiscal resources allotted annually to the PPAO.

Coroner's Comments

Please read the Coroner's Comments for #46 below. This recommendation seeks to determine, based on the number of Schedule 1 beds within a LHIN how many Patient Advocates would be necessary by appropriate benchmarking to provide both advocacy and rights advice.

[1] Local Health System Integration Act, 2006, S.O. 2006, c. 4

The Ministry of Health and Long Term Care

Recommendation #45

45. That the Ministry of Health and Long Term Care should mandate that the PPAO have a physical presence (an office) in each of the former provincial psychiatric facilities.

Coroner's Comments

Accessibility to a Patient Advocate is facilitated by the physical presence of the PPAO within the health care facility. Currently, the PPAO has office space in the 10 current or former provincial psychiatric hospitals. Their status is as invited guests. On July 11th at 1520 hours, the Psychiatric Patient Advocate Office was notified by telephone by a nurse that Mr. James was requesting to speak to a Patient Advocate. The PA promptly attended to Mr. James. Her ability to do so was facilitated by her proximity to him. This recommendation seeks to direct that the PPAO have a mandated physical presence in the 10 current or former provincial psychiatric hospitals.

Recommendation #46

46. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to require the PPAO to provide ***rights advice and advocacy*** for all psychiatric facilities under the Mental Health Act. This should include not just the former provincial psychiatric hospitals, but in addition, all schedule 1 facilities in community and general hospitals where psychiatric care is provided.

Coroner's Comments

The Psychiatric Patient Advocate Office is an "arms-length" branch of the MOHLTC which provides independent, confidential advocacy and rights advice to inpatients of the 10 current and former provincial psychiatric hospitals, and rights advice in Schedule 1 hospitals where designated by the facility as "rights adviser." Individual clients can discuss concerns about treatment, legal rights, privileges and restrictions, and quality of care in general. The advocate can assist individuals in expressing concerns or complaints to hospital staff and/or can negotiate solutions based on client instructions.

The Rights Advisor provides information to inpatients regarding legal status under the Mental Health Act and the Health Care Consent Act, and assists the individual, upon instruction, to apply to the Consent and Capacity Board to review one's legal status, apply for Legal Aid and retain counsel.[2]

[2] http://communitylinks.cioc.ca/details.asp?UseCICVw=33&RSN=3471&Number=45

The PPAO currently provides ***advocacy*** in only the 10 current and former provincial psychiatric hospitals. It provides ***rights advice*** in 54 of 58 community hospitals with Schedule 1 units. The PPAO effectively becomes the voice of the client. Evidence was heard that individuals such as Mr. James might be subjected to physical restraint in community hospitals, not just current or former psychiatric hospitals. The critical role that Patient Advocates can play in advocacy for the care of physically restrained patients was confirmed by an expert forensic psychiatrist. This recommendation seeks to expand the role of the PPAO to include their involvement in advocacy to all Schedule 1 units.

Recommendation #47

47. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to require psychiatric facilities, community and general hospitals operating schedule 1 facilities to notify the PPAO when an inpatient (client/consumer/survivor) receiving care is placed in physical restraints.

Coroner's Comments

Physical or mechanical restraint is considered the most intrusive form of restraint. As evidenced by the death of Mr. James, it can lead to lethal consequences at times. Patients/consumers/survivors may be placed in restraint due to decompensation in their illness. Due to psychotic behaviour or delusions coupled with violence, they may not be able to clearly articulate or communicate on their own behalf. The presence of a Patient Advocate could assist the patient/consumer/survivor to navigate this critical time as a voice of the client.

Recommendation #48

48. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to incorporate language that indicates that physical restraint is to be used on a "last resort" basis.[3]

Coroner's Comments

The death of Mr. James was one of two deaths of clients at CAMH in physical restraint in recent history. It lead to CAMH creating a Restraint Minimization Task Force. Historically, on August 14, 1993 Celia Thompson died of an acute pulmonary thromboembolism following a period of physical restraint at the Queen Street Mental Health Centre.

Other options for restraint are seclusion (environmental) restraint, and chemical restraint. The potential lethality of physical restraint is now clearly recognized, and this recommendation considers that the *Mental Health Act* should be amended to reflect that physical restraint only be used when absolutely necessary.

[3] MHA ="restrain" means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient;

Recommendation #49

49. That the Ministry of Health and Long Term Care should provide funding to the PPAO to allow it operate with the extended mandate of rights advice and advocacy in all psychiatric facilities including schedule 1 facilities in community and general hospitals where psychiatric care is provided. This funding should contemplate that the PPAO provide service on a 24/7 basis. This funding should be based on a benchmarking exercise conducted by the LHINs, health service providers and the PPAO. (See recommendation # 46)

Coroner's Comments

Please refer to the Coroner's Comments for recommendation # 44 and #46 above.

Currently, the PPAO operates 10 branch offices in the current or former provincial psychiatric hospitals. Their service in these offices operates from 9 a.m. to 5 p.m. Monday to Friday. Patients/consumers/survivors may require services any time of the day or night. Their crises do not contemplate limited hours of service. In the case of physical restraint, a client may be put in restraint Friday evening at 6 p.m., and not have access to a Patient Advocate until Monday morning at 9 a.m. This becomes germane in that an expert in thromboembolism gave evidence that clots can begin to form within hours of restraint.

Recommendation #50

50. That the Ministry of Health and Long Term Care should provide funding to CAMH for the following:

> " CAMH should take a leadership role with all psychiatric and schedule 1 facilities in Ontario to establish best practices guidelines for restraint, discuss restraint minimization techniques and practices, and collect data regarding incidents of restraint use. This data should be reviewed and compiled annually and presented in a report accessible on line to the public and compliant with the Personal Health Information and Protection of Privacy Act, 2004. CAMH should develop a business plan to be presented to the MINISTRY OF HEALTH AND LONG TERM CARE who should provide sufficient resources for CAMH to conduct this important work, initially, and on a continuing annual basis".

Coroner's Comments

In the Final Report of CAMH's Restraint Minimization Task Force, May 30th, 2008, the authors state, "CAMH's commitment to client-centred, recovery-oriented, holistic care and the safe provision of therapeutic mental health treatment and care underpins the desire to not only improve by way of significant restraint reduction at CAMH but, in the long run, to provide leadership to other facilities and contribute to a significant restraint reduction throughout the province". The important work of CAMH's Task Force should be shared with

other care providers in the province. Sufficient resources to allow this to happen will be required.

Recommendation #51

51. That the Ministry of Health and Long Term Care should provide financial support to the Registered Nurses' Association of Ontario (RNAO) towards RNAO's development of a nursing Best Practice Guideline (BPG) for the use of restraints in psychiatric patients, and the development of an educational toolkit for nurses.

Coroner's Comments
The RNAO have created approximately 30 Best Practice Guidelines for the nursing profession. Resources are required for the success of these BPGs.

Psychiatric Patient Advocate Office (PPAO)

Recommendation #52

52. That the PPAO should meet with the Ministry of Health and Long Term Care for the purposes of discussing models of governance which allow for sufficient institutional independence and do not contemplate interference by the Ministry with respect to the important duties of rights advice and advocacy provided by the PPAO.

Recommendation #53

53. That the PPAO should consider governance by a Board of Directors for the purpose of providing oversight and ensuring accountability of the PPAO to clients/consumers/survivors, and ultimately the public, which funds its activities.

Recommendation #54

54. That the Board of Directors could provide the PPAO with;
    54.1 Advice respecting strategic directions, performance expectations, and compelling ethical issues, and
    54.2 Direction on operational issues, budgetary planning and approval, making senior personnel decisions, and establishing a complaints process.

Recommendation #55

55. That the Board should have a membership consisting of competent members from institutions and organizations who are familiar with, and have expertise, acting in the public domain. The majority of these members should be drawn

from the consumer/survivor community and further include advocate groups such as the Empowerment Council.

Recommendation #56

56. That following establishment of a Board of Directors for governance, the PPAO should undergo a strategic planning process which re-evaluates its mandate. This process should seek to evolve from its current mandate, established in the early 1980s, to a contemporary one. As a component of its strategic planning process, the PPAO should invite stakeholders such as the Empowerment Council, CAMH, representatives from LHINs, representatives from schedule 1 facilities, and others to advise and inform their process.

Coroner's Comments for Recommendations #52-56

These recommendations arise from the evidence provided by a Program Manager for the PPAO.

The PPAO has an annual budget of 3.4 million dollars, and it is an "arms-length" branch of the MOHLTC. Its Director reports to an Assistant Deputy Minister and 2 Program Managers operationally administer the service. The Program Manager who gave evidence supervised approximately 14 persons at 5 sites.

The PPAO was created in 1983 and operated initially at the Queen Street Site of the current CAMH. It fulfills its mandate independent of government, and in evidence, the Program Manager stated that government had never attempted to interfere with the delivery of the PPAO's service. Its current mandate was created in the early 1980's, and consists of rights advice, patient advocacy, systemic advocacy, and education. It had previously had a Board of Governors, but this model of governance had been abandoned.

At the core of this body of recommendations were policies, service delivery and practices of the PPAO which the Jury appears to have identified as opportunities in need of improvement;

- The PPAO currently provides limited instructional advocacy in just the current or former provincial psychiatric hospitals. In contrast, restraint issues occur in many psychiatric facilities in Ontario.
- The PPAO provides its services for 40 hours a week operating from 9 a.m. to 5 p.m. Their services are required outside of these hours of operation.
- The PPAO requires its Patient Advocate to make notes, but these are not necessarily contemporaneous with the visits made to clients. For example, the PA who provided service to Mr. James documented only one entry prior to his death, and multiple entries following his death. This was considered acceptable practice.

These recommendations appear to suggest that the PPAO create a governance and administrative structure which would allow for broader public and client input into their processes, under the auspices of a Board of Governors. They also appear to seek an expanded revision of the PPAO's mandate to contemporize it with the current state of psychiatric care in Ontario.

Recommendation #57

57. That as a component of its strategic planning process, the PPAO should seek to review and revise its model of service delivery.

Coroner's Comments

This identifies the need for an expanded service to other schedule 1 facilities including both rights advice and advocacy provided on a 24/7 basis, which currently does not exist.

Recommendation #58

58. That the model of service delivery, should consider, as a minimum:
    58.1 That the needs of clients/consumers/survivors are required 24/7. The current availability is Monday to Friday from 9 am to 5 pm.
    58.2 How long a Patient Advocate (PA) should take to respond to the requests of clients/consumers/survivors for a meeting, effectively creating a triaging system based on the situation and intensity of need. For example, physical restraint should be considered a critical incident requiring immediate attention.
    58.3 With the consent of the client/consumer/survivor, a review of the medical file to inform the PA should occur. This would ensure that the PA would advocate most effectively on behalf of the client and address the clinical team with a more fully informed assessment of the issues.
    58.4 The method and timeliness of recording client/consumer/survivor encounters. These should be entered into the logging system immediately following any interviews, and always contemporaneously, as is done by health care providers.
    58.5 Where notes are taken by PAs, they should be kept until resolution of the situation, and where death occurs, they should be kept indefinitely.
    58.6 A document should be created which allows the PA to record clients' wishes, and this should be presented to the health care team following verbal communication.

Coroner's Comments

The PA that provided advocacy services to Mr. James did not comprehensively review his medical file prior to speaking with nursing staff. Mr. James believed that he had not been fed over the course of a weekend. In fact, he was suffering with a delusion that his food was being tampered with, and thus, he rejected his food, although special arrangements were made to provide food which had been

sealed. The PA took Mr. James's concerns to the nursing staff. This created the potential for the untenable position that the PA was advocating for the client, based on the client's delusional thinking. A full understanding of the client's condition could have been obtained with fulsome review of the medical file.

The PA that provided services to Mr. James did not log her findings and observations at the time she assessed Mr. James. These were largely entered following his death. She kept handwritten notes of her encounters with him, which she subsequently destroyed.

Instructed advocacy is where the client raises issues with the PA and these are passed on to the care providers. This would potentially be enhanced by the creation and provision of a document given to the health care team by the PA, setting out the concerns raised by the client.

Recommendation #59

59. That the PPAO should develop a training program to educate its advocates regarding the reasons why persons are placed in restraints including indication for restraint risks and benefits.

Coroner's Comments
This is self-explanatory and arises from evidence provided by the Patient Advocate involved with Mr. James.

Ontario Review Board (ORB)

Recommendation #60

60. That the Ontario Review Board should convene a Restriction of Liberties Hearing within 4 days upon notice by facilities whenever a person under ORB jurisdiction has been mechanically restrained for 7 days.

Coroner's Comments
Evidence was heard that when persons under ORB jurisdiction such as Mr. James are restrained for 7 days, a Restriction of Liberties Hearing will be convened. These Hearings can often be delayed for prolonged periods of time.

Registered Nurses' Association of Ontario (RNAO)

Recommendation #61

61. That the RNAO should develop a nursing best practice guideline for the use of restraints in psychiatric patients, in consultation with relevant stakeholders such as the Ontario Nurses' Association.

Coroner's Comments
The President of the Registered Nurses' Association gave evidence that the RNAO develops best practice guidelines for the profession to enhance the care of clients and to assist the profession with understanding best practice opportunities with respect to the provision of care.

Recommendation #62

62. That the best practice guideline should be provided to nurses with the use of a toolkit.

Coroner's Comments
The referenced "toolkit" is the educational vehicle which the RNAO utilizes to inform its members.

Recommendation #63

63. That this education should be supported by all psychiatric and schedule 1 facilities and should include the nursing clinical educator of the unit providing a lecture on the risks and benefits of restraint with the following characteristics:

63.1 Education should begin immediately upon completion of the BPG.
63.2 The education should be provided in each facility.
63.3 It should be targeted to the nursing staff and discuss the risks of pulmonary embolism.
63.4 It should be repeated biannually.

Coroner's Comments
The President of the RNAO had expertise with reference to educating nurses, and had an extensive background in education. When asked how the best practice guideline could be efficiently delivered to frontline nursing staff, she offered the elements of the educational package as detailed above as the ideal method.

The Office of the Chief Coroner (OCC)

Recommendation #64

64. That the Office of the Chief Coroner should conduct inquests into the deaths of psychiatric patients being cared for in psychiatric and schedule 1 facilities who die while being subjected to physical (mechanical) restraints. For clarity, this does not necessarily include those who die while under seclusion or chemical restraint, or while involuntarily admitted to these facilities unless they are in physical restraints. This policy is not intended to be retrospective, and should include deaths in which physical restraint was involved beginning October 10, 2008.

Coroner's Comments

The current Coroners Act provides the following direction with respect to Coroners conducting inquests into psychiatric deaths:

Deaths to be reported

10 (2) Where a person dies while resident or an in-patient in,

(a) a charitable institution as defined in the Charitable Institutions Act;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (a) is repealed by the Statutes of Ontario, 2007, chapter 8, subsection 201 (1). See: 2007, c. 8, ss. 201 (1), 232 (2).

(b) a children's residence under Part IX (Licensing) of the Child and Family Services Act or premises approved under subsection 9 (1) of Part I (Flexible Services) of that Act;

(c) Repealed: 1994, c. 27, s. 136 (1).

(d) a facility as defined in the Developmental Services Act;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (d) is repealed by the Statutes of Ontario, 2008, chapter 14, section 50 and the following substituted:

(d) a supported group living residence under the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008;

See: 2008, c. 14, ss. 50, 64.

(e) a psychiatric facility designated under the Mental Health Act;

(f) an institution under the Mental Hospitals Act;

(g) Repealed: 1994, c. 27, s. 136 (1).

(h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),

the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall

issue his or her warrant and hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (2); 1994, c. 27, s. 136 (1); 2001, c. 13, s. 10

The language allows for the discretionary power of the coroner to conduct an inquest "…if he or she is of the opinion that an inquest ought to be held".

The issue of inquests into the deaths of psychiatric patients was recently the subject of a Human Rights Tribunal Hearing, an appeal to Divisional Court which resulted in no inquest being required, and a dismissal of an application seeking a leave to appeal to the Ontario Court of Appeal. As such, it is anticipated that the current legislation and practices associated with section 10(2) of the Coroners Act will continue.

Evidence in this regard was heard from the Coordinator of the Empowerment Council, a group of consumer/survivors. There was great concern and rumours circulating in the consumer/survivor community with regard to the death of Mr. James. Physical restraint is the most intrusive form of restraint. The utilization of this type of restraint in psychiatric and schedule 1 facilities are rare events. Deaths resulting from physical restraint are very rare. The Jury is seeking an external independent review by the Coroner's Office for all such deaths.

Recommendation #65

65. That the OCC should provide all psychiatric and schedule 1 facilities with a copy of the Jury's Verdict and Recommendations and the Coroner's Verdict Explanation.

Recommendation #66

66. That the OCC will provide a report to any interested parties with respect to the recommendations within one year of the Inquest being completed, upon request.

Coroner's Comments for Recommendation #65 and 66
These are self-explanatory.

In closing, I wish 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 recollections 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, it would be greatly appreciated if it could be brought to my attention and I will gladly correct the evidence.

Respectfully submitted,

_____ _____

A.E.Lauwers, MD, CCFP, FCFP
Deputy Chief Coroner of Investigations
Province of Ontario

Date