



Ministry of
The Solicitor
General

Ministère du
Solliciteur
général

Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury Verdict du jury du coroner

COPY

We the
undersigned
Nous soussigné

Paul AUSDERAU

of Orillia
de

Frances BROOKS

of Orillia
de

Lynn BALL

of Barrie
de

Francis McMAHON

of Barrie
de

Daniel MEANY

of Barrie
de

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

Surname / Nom de famille

BOLGER

Given names / Prénom

John Carl

aged **54**
âgé(e) de

held at **Highwayman Inn 201 Woodside Dr. Orillia**
qui a été menée à

From the
du

December 5th

to the
a la

December 13th

20 05

By
Par

Dr.

P. Savage

Coroner for Ontario
coroner pour l'Ontario

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

1. Name of deceased
Nom du (de la) défunt(e)

John Bolger

2. Date and time of death
Date et heure du décès

December 21/03

3. Place of Death
Lieu de décès

Toronto, Ontario

4. Cause of death
Cause du décès

Blunt Force Trauma

5. By what means
Circonstances entourant le décès

Suicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

JURY RECOMMENDATIONS CONCERNING THE DEATH OF JOHN BOLGER

Recommendation # 1

Establishment of a Multi-Disciplinary Task Force


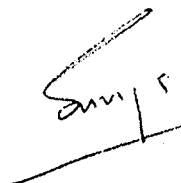
We recommend that the Ministry of Health and Long-Term Care and the Ministry of community Safety and Correctional Services create a multi-disciplinary task force, with representation from the various stakeholders, including consumers of mental health services, to develop guidelines for non-Schedule 1 hospitals to use when those hospitals are housing Form 1 patients who are awaiting transfer to Schedule 1 facilities.

The task force should consider the various medical, psychiatric and security concerns involved in housing Form 1 patients in venues not specifically designated, designed or constructed for housing such patients.

The task force should consider recommending amendments to the Mental Health Act to recognize that non-Schedule 1 facilities are in fact called upon to house Form 1 patients who are awaiting transfer to Schedule 1 facilities.

The Guidelines should :

- a) be sufficiently flexible to protect a patient's dignity and to allow for clinical decision-making while ensuring that appropriate safeguards are taken to maximize the patient's safety.
- b) recognize the importance of identifying and clarifying who is primarily responsible for determining the appropriate level of security.
- c) address the need to have that responsible party establish, and reassess as required, the appropriate level of security for individual patients, having regard to the patient's mental status, clinical needs, risk level and physical surroundings.
- d) address the need to have a system of communication so that those involved in the surveillance and assessment of Form 1 patients receive all relevant information about the patient, the level of risk involved and the level of security required, within the bounds of patient confidentiality and privacy legislation.
- e) address issues around training of security personnel and paid duty police officers engaged by hospitals with respect to Form 1 patients awaiting transfer to Schedule 1 facilities.

  M.D.



Recommendation #2:

The need for urgent change

We recommend that recommendation #1 be implemented as soon as possible

Rationale:

Since non-Schedule 1 facilities are at times unable to transfer patients to a Schedule 1 facility "forthwith" as required by the Mental Health Act and given that non-Schedule 1 facilities are therefore responsible for the safety and security of Form 1 patients while awaiting appropriate transfers, it is urgent that the safety and security of Form 1 patients, the public and security providers be addressed in a timely fashion.

Recommendation # 3

MHCP Pilot Project

We recommend that the Mental Health Centre Penetanguishene (MHCP) proceed with the development of a pilot project for implementation in early 2006 to have physicians at MHCP and physicians at non-Schedule 1 hospitals within its catchment area communicate directly where issues are raised concerning the medical clearance of Form 1 patients awaiting transfer to MHCP.

Rationale:

With communication such as this between the hospitals, all relevant information is considered and discussed in an open dialogue.

Handwritten signatures and initials:
L. C. S. M. P.

Handwritten signature:

Verdict Explanation

**Inquest of John Bolger
Inquest December 5 - 13, 2005
201 Woodside Avenue
Orillia, Ontario**

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict and 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:

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Investigating Officer:

Detective Constable Brian Kay
Barrie Police Services
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Coroner's Constable:

Special Constable Geri Oke
Peel Regional Police
7755 Hurontario Street
Brampton, Ontario
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Court Reporter

Phyllis Torrance
Simcoe Court Reporting
134 Collier Street
Barrie, Ontario
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Parties with standing:

Adam Lees
Son of Deceased

Police Association

Ministry of the Solicitor General

Orillia Soldiers Memorial Hospital

Penetang Ontario Hospital

Dr. Karen Kennedy
Dr. Dave Collins

REPRESENTED BY:

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Sandra Drozd
80 Dufferin Avenue
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SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

Mr. John Bolger was a gentleman who was admitted under the Mental Health Act, taken to the Collingwood Hospital, found to have significant medical issues with overdose of Methanol. He was transferred to the Orillia Soldier's Memorial Hospital for dialysis and acute medical management. He was medically cleared and while awaiting transfer to a Schedule 1 hospital broke through a window plummeting three floors to the ground. Medical resuscitation and surgery took place both in Orillia and in Sunnybrooke Hospital where he was later transferred but in spite of this he died on December 21, 2003.

As he was in custody this was a mandatory inquest and the inquest took place at the Orillia Highwayman Inn December 5 to December 13, 2005. There were six parties granted standing represented by Council. There were seventeen witnesses. The inquest ran for six days. The jury deliberated for six and one half hours before giving their verdict. (At the end of jury deliberation and before presentation of the verdict one jury member in the jury room suffered chest pain. I was called to the jury room and sent the other four jury members away with the Constable, organized medical care for the stricken juror and arranged for her to go by ambulance to the Orillia hospital. Her signature does not appear on the jury verdict and she was excused from jury duty when the inquest reopened after the deliberation of the jury and before the verdict was accepted by the Coroner and verified by the Jurors themselves.)

The findings of the Jury were as follows:

The name of the deceased - John Bolger
Date of Death - December 21, 2003
Place of Death - Sunnybrooke Hospital, Toronto
Cause of Death - Blunt Force Trauma
By What Means - Suicide

Recommendations:

The Jury went on to make three recommendations.

1. Establishment of a Multi-Disciplinary Task Force

We recommend that the Ministry of Health and Long-Term Care and the Ministry of community Safety and Correctional Services create a multi-disciplinary task force, with representation from the various stakeholders, including consumers of mental health services, to develop guidelines for non-Schedule 1 hospitals to use when those hospitals are housing Form 1 patients who are awaiting transfer to Schedule 1 facilities.

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Recommendation #2:

The need for urgent change

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Rationale written by the Jury:

Since non-Schedule 1 facilities are at times unable to transfer patients to a Schedule 1 facility "forthwith" as required by the Mental Health Act and given that non-Schedule 1 facilities are therefore responsible for the safety and security of Form 1 patients while awaiting appropriate transfers, it is urgent that the safety and security of Form 1 patients, the public and security providers be addressed in a timely fashion.

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Rationale written by the Jury:

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Coroner's Comments

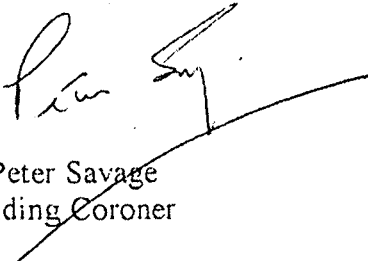
I believe the recommendations are extremely clear and need very little comment with these exceptions. In the first recommendation the Ministry of Community Safety and Correctional Services is put in along with the Ministry of Health because the jury heard evidence from witnesses that the Ministry of Community Safety and Correctional Services has expertise both in the techniques and training of people for safely guarding people who are actually dangerous to themselves or to others and that this expertise would be very beneficial in guarding the safety of patients who are awaiting transfer to a Schedule 1 hospital for psychiatric evaluation.

The jury heard evidence that there was need to house patients who were on a Form 1 in the General hospitals, while awaiting a bed in a proper Schedule 1 Hospital.

This situation is common and is not covered in the Mental Health Act. Thus they felt there was an urgent need to amend the Mental Health Act in order to protect patients safety and dignity. Because this situation is common and ongoing in the province they felt this matter had to be addressed as soon as possible.

Closing comment

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that it is not the verdict. Likewise many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. IF any party feels that I 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 error.


Dr. Peter Savage
Presiding Coroner

JAN 18 2006
Date