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INQUEST

TOUCHING THE DEATH OF

Kerri Nicole CUDDY

JURY VERDICT AND RECOMMENDATIONS

B.M.B.P.
Deputy Chief Coroner
(Inquests)

DEC 20 2004

Office of the Chief Coroner

December , 2004



Office of
The Chief
Coroner
Bureau du
coroner
en chef

Verdict of Coroner's Jury Verdict du jury du coroner

We the undersigned Saida Adamji of Mississauga
 Nous soussigné Susan de Leon of Brampton
Michael DiFranco of Mississauga
Arthur Evans of Mississauga
Mary Anne Kieran of Mississauga

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

Surname / Nom de famille Cuddy Given names / Prénom Kerri Nicole

aged **21** held at the Coroner's Inquest Courts, Brampton, Ontario
 âgé(e) de qui a été menée à

from the **13th Dec.** to the **16th Dec.** 20 **04**
 du a la

By Dr. **William J. Lucas MD** Coroner for Ontario
 Par coroner pour l'Ontario

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

- | | |
|--|--|
| 1. Name of deceased
Nom du (de la) défunt(e) | Kerri Nicole Cuddy |
| 2. Date and time of death
Date et heure du décès | 1:27 p.m. on June 16th, 2003 |
| 3. Place of Death
Lieu de décès | Credit Valley Hospital, Mississauga |
| 4. Cause of death
Cause du décès | Stab wound to chest |
| 5. By what means
Circonstances entourant le décès | Suicide |

M.A. Kieran
 Original signed by: Foreman/Président du jury

Saida Adamji
Susan de Leon
Michael DiFranco
Arthur Evans
Mary Anne Kieran
 Original signed by jurors/jurés

The verdict was received on the **16** day of **December** 20 **04**
 Ce verdict a été reçu par moi le

W.J. Lucas
 Original signed by Coroner

Distribution: Original - Regional coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef

Copy - Crown Attorney / Copie - Procureur de la Couronne

JURY RECOMMENDATIONS

These Recommendations are not necessarily in order of priority.

We the jury submit the following recommendations for consideration:

1 That it be taken under consideration that as part of the discharge process for patients determined to be in need of continuing care, that it be clearly noted in writing on the discharge papers the identity of the attending outpatient psychiatrist. The purpose being to make it clear to the members of the continuing care agencies who the psychiatric physician is. In the event that the patient does not have one, to designate a psychiatrist to that patient in order to ensure a continuum of care.

2 We also recommend that the communication process between the front line workers of community care agencies, such as visiting nurses and or social workers, and the patient's psychiatrist and family physician be reviewed with a view to increase the flow of information between these parties especially in the period immediately after discharge. In particular, we the jury, recommend that a copy of any notes taken by the visiting nurse and or social worker be forwarded to the attending psychiatrist and family physician on a per visit basis .

Rationale: The jury is of the opinion that the rationale for both of the above recommendations flows from the same consideration. As was heard in evidence, the period immediately after discharge is recognized through statistical evidence to be a period of increased possibility of suicide. We therefore feel that a heightened and more clearly directed flow of written communication between designated caregivers and the professionals involved would benefit patients.

In closing the jury wishes to extend our sincere condolences to the family of Kerri Cuddy while they continue to deal with their loss.

M A Kellan

E Lucas

VERDICT EXPLANATION

INQUEST Concerning the Death of Kerri Nicole CUDDY

Location: Brampton Provincial Offences Courthouse
5 Ray Lawson Blvd, Brampton

Dates of Inquest: December 13-16, 2004

Presiding Coroner: William Lucas, Regional Supervising Coroner

Coroner's Counsel: David Carruthers, Assistant Crown Attorney
Office of the Chief Coroner
26 Grenville St.

Investigating Officer: Det. Sgt. Domenic Beckett
Ontario Provincial Police
OCC Inquest Unit

Coroner's Constable: P.C. Bill Annand
Ontario Provincial Police
Niagara Detachment

Court Reporter: Lisa Cumber
Halton Reporting Services
Tel: 905-541-9323

Parties with Standing:

1. Credit Valley Hospital, Mississauga
Represented by: Ira G. Parghi
Borden Ladner Gervais LLP
2. Dr. Grant Moore and Dr. Louis Peltz
Represented by: Estée L. Garfin
Lenczner Slaght Royce Smith Griffin LLP

3. Peel Regional Police Service, and Officers
Represented by: William R. MacKenzie

In this document I have written a brief summary of the circumstances surrounding Kerri Cuddy's death, as well as a brief synopsis of the issues explored at the inquest. Where it was felt to be of potential assistance, I have also commented on my understanding of the reasons behind the jury's recommendations. I wish to stress that it comprises my own interpretation of the evidence and of the jury's reasoning. It is not intended to replace the actual evidence presented to the jury, but is provided to assist the reader in interpreting the context in which their verdict and recommendations were made, so that those recommendations can be better understood. This verdict explanation is not intended to replace the jury's verdict.

Brief Summary of the Circumstances of the Death and Issues Addressed at the Inquest:

Kerri Nicole Cuddy was a 21 year-old who had a history of mental health problems dating back several years. These included a learning disability, communication difficulties, impulsivity and bulimia. In early 2000, she began to experience severe depressive symptoms, and sought medical help. In the fall of that year, she was admitted to a psychiatric facility for a period of about 4 weeks after taking an overdose of medications.

After discharge she was followed quite regularly as an outpatient by a psychiatrist, but continued to have impulsivity problems, including frequent over-use of alcohol and non-compliance with medical treatment. On occasions she would arrive for medical appointments in an intoxicated state, so her psychiatrist let it be known that treatment would not continue if she persisted with this type of behaviour. She also exhibited delusions and hallucinations.

On May 21st, 2003 she presented to the Credit Valley Hospital with symptoms of depression, delusions and paranoia. She was admitted for assessment on a Form One under the *Mental Health Act*, and was under the care of a different psychiatrist. A diagnosis was made of "personality disorder with psychotic episodes", and it was decided that the hospitalization would be for brief intervention only.

On May 28th, a social worker met with Ms. Cuddy, determined that she would need outpatient support upon discharge and arranged for a family meeting the next day. At that meeting it became apparent that the family would also need supports to assist them in coping with Ms. Cuddy's condition. Discharge was confirmed for May 29th. Ms. Cuddy was not opposed, but her parents were apparently anxious about the discharge decision. The family also expressed a wish to have Ms. Cuddy cared for by the new (inpatient) psychiatrist rather than her previous (outpatient) psychiatrist.

Arrangements were made through the Community Care Access Centre (CCAC) for home visits by both a mental health nurse and a community social worker. Both the mental health nurse and the social worker attended the family residence on a twice-weekly basis, beginning the first week of June.

During the weekend of June 14 and 15, Ms. Cuddy exhibited signs of significant deterioration. She became angry at her mother over a minor dispute, and "trashed" the house. She also went to bed with a kitchen knife in her possession because of paranoid ideation. The social worker was contacted on the Sunday and arranged to attend the residence on Monday morning while the mental health nurse was also present.

On June 16th Ms. Cuddy was apparently still quite disturbed. The nurse did not remain long at the residence, but indicated that she would alert "the psychiatrist" about the weekend crisis. The social worker cancelled her other morning appointments and remained at the home to try to convince Ms. Cuddy to go to hospital for medical attention. After more than two hours of negotiation, it appeared that Ms. Cuddy was willing to comply. The social worker volunteered to remain longer to assist Mrs. Cuddy with getting her daughter to the hospital. Mrs. Cuddy felt that she could manage on her own, so the social worker left.

Shortly before noon, as they were departing the residence, Mrs. Cuddy perceived that her daughter was concealing a knife on her lower leg in her sock. When confronted Ms. Cuddy bolted down to the basement of the residence and locked herself in a bathroom, refusing to come out. Mrs. Cuddy contacted the social worker, who in turn advised her to contact the Family Physician. The physician advised calling the police.

Several officers were dispatched to the residence with preliminary information that there was a mentally disturbed person barricaded in a washroom, possibly armed with a knife. One of the officers commenced negotiations with Ms. Cuddy through the bathroom door. Her responses were initially clear and her voice was strong. She refused to come out of the bathroom and would not admit to being in possession of a knife. She also resisted the officer's attempts to enter by pushing against the door.

Over the next several minutes, Ms. Cuddy's responses became less frequent and her voice less forceful. Eventually she stopped responding altogether. Fearing for her well-being, the officer in charge determined that they should attempt to breach the door and secure the situation. On entering, they witnessed Ms. Cuddy lying on her back, brandishing a large knife and attempting to raise it towards her face.

O.C. (pepper) spray was used and the knife was released. Ms. Cuddy was dragged feet first from the bathroom, resisting strenuously, and was handcuffed. Due to O.C. spray contamination of the area, officers lifted Ms. Cuddy and began to carry her upstairs while she continued to passively resist by lifting her feet. At the top of the basement stairs Ms. Cuddy went vital signs absent.

Officers immediately began to search for signs of injury to explain her sudden collapse. Upon lifting her sweatshirt and sweater, they discovered a kitchen steak knife penetrating her left upper chest. They immediately began C.P.R. and called for an ambulance. Unfortunately, all further attempts at resuscitation, both prior to and after arrival at hospital were unsuccessful.

Postmortem examination revealed the presence of two stab wounds to the left chest, one superficial and one deep. The fatal wound penetrated the pericardial sac and the left ventricle, causing exsanguination into the chest cavity.

Because Kerri Cuddy died while in the custody of Peel Regional Police officers who had arrested her under the *Mental Health Act*, Section 17, a mandatory inquest was required, in accordance with Section 10 (4) of the *Coroners Act*.

Verdict of Coroner's Jury

Name of deceased:	Kerri Nicole Cuddy
Date and time of death:	1:27 p.m. on June 16 th , 2003
Place of death:	Credit Valley Hospital, Mississauga
Cause of death:	Stab wound to chest
By what means:	Suicide

Jury Recommendations

We the jury submit the following recommendations for consideration:

1. That it be taken under consideration that as part of the discharge process for patients determined to be in need of continuing care, that it be clearly noted in writing on the discharge papers the identity of the attending outpatient psychiatrist. The purpose being to make it clear to the members of the continuing care agencies who the psychiatric physician is. In the event that the patient does not have one, to designate a psychiatrist to that patient in order to ensure a continuum of care.
2. We also recommend that the communication process between the front line workers of community care agencies, such as visiting nurses and or social workers, and the patient's psychiatrist and family physician be reviewed with a view to increase the flow of information between these parties especially in the period immediately after discharge. In particular, we the jury, recommend that a copy of any notes taken by the visiting nurse and/or social worker be forwarded to the attending psychiatrist and family physician on a per visit basis.

Rationale:

The jury is of the opinion that the rationale for both of the above recommendations flows from the same consideration. As was heard in evidence, the period immediately after discharge is recognized through statistical evidence

to be a period of increased possibility of suicide. We therefore feel that a heightened and more clearly directed flow of written communication between designated caregivers and the professionals involved would benefit patients.

In closing the jury wishes to extend our sincere condolences to the family of Kerri Cuddy while they continue to deal with their loss.

Coroner's comment:

Recommendation #1:

Confusion arose for the jury as to whether Ms. Cuddy actually had an outpatient psychiatrist to oversee her care and who could provide assistance in a crisis during the time period after her discharge from hospital. The inpatient psychiatrist for her May 21st – 28th admission had made it clear that he was referring Ms. Cuddy back to her original outpatient psychiatrist. That psychiatrist had indicated at one point that she could not continue to see Ms. Cuddy if she was not compliant with treatment and showed up for appointments in an intoxicated state. The family in turn, had requested a change in outpatient psychiatrists, and had initiated a request through the Family Physician for a new referral.

The records of the community mental health nurse indicated both the inpatient and outpatient psychiatrists, as well as the Family Physician as contacts for Ms. Cuddy's ongoing care. On June 16th, the nurse indicated to the family that she would make "the psychiatrist" aware of Ms. Cuddy's crisis over the previous weekend. She called the office of the inpatient psychiatrist, who had indicated on discharge that he would have no further involvement, and left a message.

On June 16th, Ms. Cuddy needed urgent crisis intervention and psychiatric assessment. It is my view that contacting a psychiatrist for advice at the time of her crisis would not have been of much assistance to Ms. Cuddy or her family. The hospital social worker and the community agencies had made several phone numbers for support and crisis agencies available to the Cuddy family. Unfortunately, in their distress they did not think to contact any of these agencies.

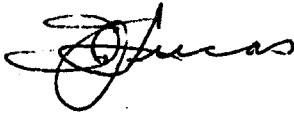
The jury was obviously concerned with its perception that there appeared to be a lack of continuity in care with no psychiatrist apparently overseeing Ms. Cuddy's case. Better clarification at the time of discharge from hospital would remedy this.

Recommendation #2:

The evidence from the community health nurse was that the assessments and notes that she compiled in the case file were not routinely shared with any of the patient's/client's physicians. The jury perceived that those notes contained potentially valuable clinical information and that there should be a mechanism to regularly provide feedback of this information to the physicians. This might assist significantly in clinical treatment decisions.

In closing I would stress once again that this document has been prepared solely for the purpose of assisting the reader in understanding the inquest jury's verdict and recommendations. It does not replace the verdict and recommendations, but rather consists of my comments and recollections of the evidence presented, on which I believe the jury based their conclusions. Should any party feel that my recollection or interpretation has been incorrect or misrepresented, kindly bring the matter to my attention so that any error might be appropriately corrected.

Respectfully submitted,



William J. Lucas, MD CCFP
Regional Supervising Coroner
Central Region

December 17, 2004

