



Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury Verdict du jury du coroner

We the
undersigned
Nous soussigné

Karen Burrill

of
de

Georgetown, Ontario

Viola Burton

of
de

Georgetown, Ontario

Sean Quinn

of
de

Georgetown, Ontario

Bonita Hatcher

of
de

Georgetown, Ontario

Betty-Jean Wambolt

of
de

Georgetown, Ontario

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

GAGNE

Given names / Prénom

Ronald James

aged **21**
âgé(e) de

held at Halton Hills Civic Centre, 1 Halton Hills, Ontario
qui a été menée à

from the **13th November**
du

to the **16th November**
à la

20 07

By
Par

Dr.

Coroner for Ontario
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) | Ronald James GAGNE Jr. |
| 2. Date and time of death
Date et heure du décès | November 22, 2006 at 1:04 a.m. |
| 3. Place of Death
Lieu de décès | Milton District Hospital, 30 Derry Road, East, Milton |
| 4. Cause of death
Cause du décès | Hanging by ligature |
| 5. By what means
Circonstances entourant le décès | Suicide |

Sean Quinn

Original signed by: Foreman/Président du jury

Karen Burrill

Viola Burton

Bonita Hatcher

Betty-Jean Wambolt

Original signed by jurors/jurés

The verdict was received on the
Ce verdict a été reçu par moi le

16th

day of

November

20 07

Dr. David G. Schooling

Original signed by Coroner

JURY RECOMMENDATIONS

1. *Consideration should be given to revising the suicide prevention policy and procedures to require that any information provided to staff that an inmate be suicidal be documented in an occurrence report and forwarded to healthcare for review and placement in the inmate's medical file, as well as institutional file. To follow through with existing suicide prevention policies and procedures (page 9 of 10) "Information from the Public" outlining where the Operational Manager will meet with or contact the person who initiated the occurrence report*
2. *Consideration should be given to revising the Suicide Screening Tool to include a detailed reference to the information obtained/source(s) that led to the screening tool being used, i.e. information from inmate, other inmates, family, lawyer, etc. The Suicide Screening Tool should also be completed in its entirety with no optional sections.*
3. *Consideration should be given to putting a policy in place that requires staff to forward any Suicide Screening Tools completed to the psychiatrist so that they can be reviewed on the next day scheduled for the psychiatrist to be in and a method implemented to effectively communicate back to all floor staff any changes required for additional monitoring.*
4. *A policy should be considered that requires Records Staff to review remand warrants for special endorsement by the court for psychiatric or medical attention, etc. and forward the information to Healthcare for review and placement in the inmate's medical file.*
5. *Consideration should be given to increasing psychiatric resources including sufficient access to a mental health nurse to ensure that on each scheduled shift, the psychiatrist can review the Suicide Screening Tools completed by staff, see all inmates on suicide watch, and meet with those inmates with appointments within 7 days of the appointment being made.*
6. *Consideration should be given to establish databases so that medical records could be stored electronically and linked to OTIS records so that any penal institution nationwide would have access to full medical history.*
7. *An effort should be made to forge better links with community agencies to enable continuation of mental health treatment and prescription medication upon release back into the community.*
8. *A study should be undertaken to evaluate the possibility of attaching or embedding the detox strip into the furthest point of each range.*
9. *Consideration should be given to undertake a study to enhance the visibility within each cell block range by using remote surveillance cameras located strategically to broadcast to monitors situated at staff workstations.*

VERDICT EXPLANATION

Name of the Deceased: RONALD GAGNE JR.
Dates of Inquest: November 13th-16th 2007
Location of Inquest: Council Chambers,
Halton Hills Drive
Georgetown, Ontario

I intend to give a brief synopsis of the issues presented at this inquest and explain in some detail the reasons for the Jury's recommendations. I would like to stress that much of this will be my own interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to better understand the verdict and the recommendations of the jury and is not intended to replace the jury's verdict.

Participants

Counsel to the Coroner:	Ms. Monica MacKenzie Assistant Crown Attorney 491 Steeles Avenue West Milton, Ontario, L9T 1Y7 Phone: 905-693-3054
Investigating Officer:	Detective Constable Michael Leighton Halton Regional Police Service 490 Childs Drive, Milton, Ontario, L9T 5G2 Phone: 905-825-4747 ext2447
Coroners Constable:	Thomas Chapman Halton Regional Police Service 490 Childs Drive Milton, Ontario, L9T 5G2 Phone: 905-827-4747 ext2405
Court Reporter:	Karen Williams 3400 Lakeshore Blvd. West, #208 Toronto, Ontario, M8W 4Z9 Phone: 416-579-0609

PARTIES WITH STANDING

Ministry of Community Safety &
Correctional Services

Jordana K. Joseph
Ministry of the Attorney General
77 Grenville Street, 8th Floor
Toronto, Ontario, M5S 1B3
Phone: 416-314-6066

The Gagne Family

Roland Gagne Sr.

Summary of the Circumstances of the Death:

Ronald James Gagne was born in Sudbury on October 1, 1985. For the first six months of his life he spent a considerable amount of time in the Hospital for Sick Children in Toronto following a severe bowel infection which required surgery. He was hospitalized again at the age of two because of severe burns to his feet and legs caused by hot bathwater of unknown manner. Following this he was taken into the custody of the Children's Aid Society in Sudbury and became a Crown Ward and was moved to various foster homes in Ontario. During his involvement with the Children's Aid Society it was noted the Ronald Gagne suffered from Attention Deficit Hyperactivity Disorder, (ADHD) and was subject to probable depressive symptoms. He was assessed at the Sudbury Algoma Hospital in 1990 and again in 1996 for depressive symptoms.

On November 7th 2000 Ronald Gagne stole a bottle of his mother's prescription drugs and swallowed them in an attempt to commit suicide. He was detained under a form one of the Mental Health Act and was in the Sudbury Algoma Hospital.

In April of 2006 Ronald Gagne was detained at the Maplehurst Correctional Facility in Milton as he had been arrested on a variety of charges. While there he was assessed by a psychiatrist and was in fact placed on a suicide watch for three days. Following this he was prescribed two major anti-depressant drugs. He was discharged in May of 2006.

In September 2006 Ronald Gagne was arrested by the Ontario Provincial Police in Caledon, Ontario. After appearing in court in Orangeville he was remanded to Maplehurst Correctional Facility in September 30, 2006. On admission to the facility Mr. Gagne was interviewed by a correctional officer and also by a registered nurse. On October 3, 2006 Mr. Gagne submitted a Ministry of Public Safety and Security request form to see a doctor about his medication needs. He was seen by the doctor on October 6, 2006 and it was found that he may have taken his anti-depressant medication while he was free during the Summer of 2006 and he may have not. In any case his medication was resumed.

On October 20, 2006, Mr. Gagne spoke to his ex-girlfriend via telephone and indicated that he was suicidal. The girlfriend informed the victims father who then contacted Maplehurst Correctional Facility and spoke to the staff. On the same day a mental health nurse had an interview with Mr. Gagne who stated he was not suicidal but she completed an Ontario Correctional Services Suicide Screening Tool on Mr. Gagne and this indicated there was not a need to initiate a suicide watch. However an appointment was made for him to see the facility psychiatrist at the next available time. On October 30, 2006 Mr. Gagne submitted another form requesting an interview with a psychiatrist. At that time Mr. Gagne was already on the facility list to be seen by a psychiatrist. On November 3 Mr. Gagne was seen again by the physician at Maplehurst and his medication dosages were increased and he was once again referred to see the institutional psychiatrist. On November 16 Mr. Gagne appeared once again in Orangeville for judicial pre-trial and missed his appointment with the psychiatrist.

On November 21, 2006 Mr. Gagne submitted a Ministry of Public **Safety and Security** Request Form advising once again that he wished to see a psychiatrist and he stated that he had been trying to do so since September of 2006. It should be noted that during the attendance at court on November 16, 2006, the judge ordered that Mr. Gagne have access to a psychiatrist at his place of detention and a record of such was made on his remand warrant at that time.

On November 22, 2006 at approximately twelve twenty five a.m. Mr. Gagne was found hanging in his cell from a torn up bed sheet. He was transferred to the Milton Hospital and was pronounced dead in the Emergency Department. An autopsy was performed in Hamilton.

In April 2007 a former inmate on Mr. Gagne's unit was attending the Halton Regional Police Services in Milton on an unrelated matter and at that time the inmate advised the Detective Constable that he was aware of a suicide note that had been written by Mr. Gagne and in the possession of another inmate who had been in Maplehurst at the time and had been to British Columbia while he was on remand. This inmate returned to Ontario and he was interviewed and he stated the suicide note was in his Bible in British Columbia at his residence. This was recovered by the RCMP and was found to be dated six days before the suicide.

INQUEST NOTES

1. This was a mandatory inquest conducted by order of the Chief Coroner of Ontario under Section 25, Subsection 1 of the Coroners act.
2. The inquest lasted four days.
3. There was a total of eighteen witnesses and forty-three exhibits. The jury took three and a half hours to reach their verdict.

Verdict of Coroner's Jury

1. Name of Deceased: Ronald James GAGNE Jr.
2. Date and Time of Death: November 22, 2006 at 1:04 a.m.
3. Place of Death: Milton District Hospital, 30 Derry Road East, Milton
4. Cause of Death: Hanging by ligature
5. By What Means: Suicide

Attached to the verdict the jury also made the following recommendations:

1. Consideration should be given to revising the Suicide Prevention Policy and Procedures to require that any information provided to staff that an inmate be suicidal be documented in an occurrence report and forwarded to Healthcare for review and placement in the inmate's medical file, as well as institutional file. To follow through with existing Suicide Prevention Policies and Procedures (page 9 of 10) "Information From The Public" outlining where the Operational Manager will meet with or contact the person who initiated the occurrence report.

Rational: To ensure all available information is documented in inmates files so any professional reviewing inmates file has all pertinent information in making a decision on inmates well being.

Coroners Comment: This refers to the fact that evidence was heard that when the father of the deceased phoned the Maplehurst Facility there existed no record of his phone call. It is noted however that on the same day the psychiatric nurse did perform a Suicide Screening Tool Assessment. From evidence we heard it might be difficult to place medical evidence on the inmate's general institutional file because of privacy consideration

2. Consideration should be given to revising the Suicide Screening Tool to include detailed reference to the information obtained/sources that led to the screening tool being used, i.e. information from inmate, other inmates, family, lawyers, etc. The Suicide Screening Tool should also be completed in its entirety with no optional sections.

Rational: To ensure all information is available for effective assessment.

Coroners Comment: We heard from a psychiatrist that the tool was oversensitive and tended on the side of caution in that people who were not suicidal were often placed on suicide watch. The tool is a form which can be filled in in several parts with some parts being optional. The jury is suggesting that all the forms should be filled in on every case.

3. Consideration should be given to putting a policy in place that requires staff to forward any Suicide Screening Tools completed to the psychiatrist so that they can be reviewed on the next day scheduled for the psychiatrist to be in and a method implemented to effectively communicate back to all floor staff any changes required for additional monitoring.

Rational: To ensure an extra check and balance to prevent someone from falling through the cracks and so that priority can be assigned not just based on outward appearances.

Coroners Comment: This recommendation is self explanatory

4. A policy should be considered that requires Records staff to review remand warrants for special endorsement by the court for psychiatric or medical attention, etc. and forward information to Healthcare for review and placement in the inmate's medical file.

Rational: To ensure all information is available and acted upon.

Coroners Comment: The victim in actual fact had an endorsement by the court for psychiatric or medical attention when he did appear in court on November 16, 2006. It may well be that this endorsement was missed when he returned to Maplehurst

5. Consideration should be given to increasing psychiatric resources including sufficient access to a mental health nurse to ensure that on each scheduled shift, the psychiatrist can review the Suicide Screening Tools completed by staff, see all inmates on suicide watch, and meet with those inmates with appointments within seven days of the appointment being made.

Rational: To ensure inmates have sufficient access to see the psychiatrist in a timely manner.

Coroners Comment: We heard in the evidence from a consulting psychiatrist at Maplehurst that although the number of hours assigned to psychiatrists is increased there is room to have more psychiatric involvement as in his opinion approximately sixty percent of the inmates at Maplehurst do require some degree of psychiatric attention.

6. Consideration should be given to establish databases so that medical records could be stored electronically and linked to OTIS records so that any penal institution nationwide would have access to full medical history.

Rational: To ensure all available information is documented in inmates files so any professional reviewing inmates file has all pertinent information in making a decision on an inmates well being.

Coroners Comments: This particular consideration is self explanatory but we did hear that this may well involve privacy issues

7. An effort should be made to forge better links with community agencies to enable continuation of mental health treatment and prescription medication upon release back into the community.

Rational: To prevent inmate from going from full medical care to no medical care in one step.

Coroners Comment: The consulting psychiatrist in his evidence was very clear on this matter. Apparently inmates do leave the institution and often fail to take their medications and they have no means of getting repeat prescriptions because they do not have a family doctor or any idea of how to obtain follow up or counseling

8. A study should be undertaken to evaluate the possibility of attaching or embedding the detect strip into the furthest point of each range.

Rational: To allow for all pipe chase doors to remain closed at all times unless maintenance is being performed in the pipe chase areas in order to maintain full view of the range.

Coroners Comment: This recommendation comes from evidence we heard that the detect strip which is part of the electronic record keeping as to when the patrol officer's make their rounds at night is situated in what is known as a pipe chase room which is located next to room thirteen, the last cell on the range. This pipe chase room is for services like sewage and water and has a door. Inside is the strip which is used to electronically record the visit. An officer stated that when the door is half open they cannot see well into the cell, (number thirteen) or somebody could be behind the door. The correctional officer stated he prefers to have the door either fully open or fully closed so that he can see along the corridor more easily. Ofcourse if the detect strip was at the furthest point of the range the officer would have to walk past all the cells and look in and there would be no chance they could miss out on cell thirteen where the victim was. In actual fact it turned out that they found him hanging very quickly after the event occurred

9. Consideration should be given to undertake a study to enhance the visibility within each cell block range by using remote surveillance cameras located strategically to broadcast monitors situated at staff workstations.

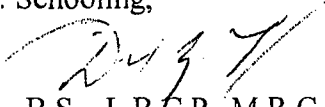
Rational: To maintain maximum view of the range.

Coroners Comment: This is self explanatory except that it would infringe on the privacy of inmates if the surveillance cameras were to point straight into their cells

Although asked to do so the jury did not state who these recommendations were to be addressed to but I think we can assume to the Ministry of Community Safety and Correctional Services.

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 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 error.

D.G. Schooling,



M.B., B.S. , L.R.C.P., M.R.C.S., L.N.C.C.