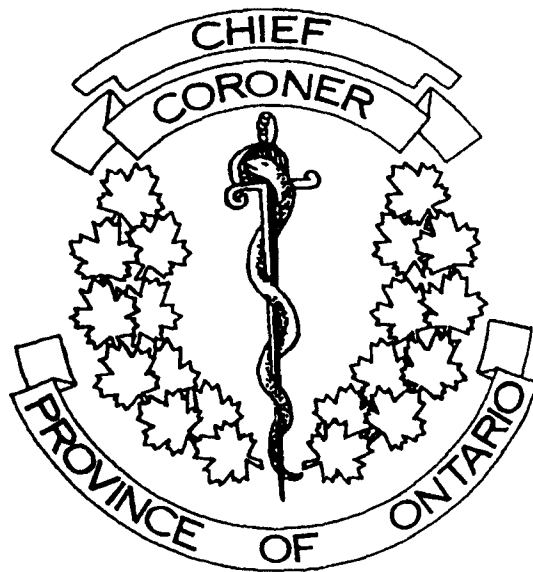


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Advocate Office



**INQUEST**

**TOUCHING THE DEATH OF**

**Rinchen Tsering KHEDUP**

**JURY VERDICT AND RECOMMENDATIONS**

**March 2007**



Office of  
The Chief  
Coroner

Bureau du  
coroner  
en chef

# Verdict of Coroner's Jury

We the  
undersigned

**Laurie Reid** of **Toronto**

**Richard Spiegelman** of **Toronto**

**Brian Brady** of **Toronto**

**Moirra Connolly-Stringer** of **Toronto**

**Amit Patel** of **Toronto**

the jury serving on the inquest into the death of :

Surname:

**KHEDUP**

Given names:

**Rinchen Tsering**

Aged: **25 yrs** held at **Coroner's Inquest Court, 15 Grosvenor St., Toronto, Ontario**

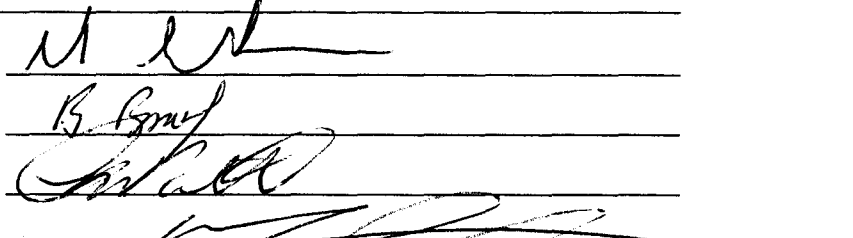
From the **26<sup>th</sup> March** to the **26<sup>th</sup> March** 20 **07**

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

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

- |                           |   |
|---------------------------|---|
| 1. Name of deceased       | <b>Rinchen Tsering Khedup</b>                     |
| 2. Date and time of death | <b>18 April 2005 11:02 a.m.</b>                   |
| 3. Place of Death         | <b>William Osler Health Centre, Etobicoke, ON</b> |
| 4. Cause of death         | <b>complications of hanging</b>                   |
| 5. By what means          | <b>suicide</b>                                    |

  
Original signed by: Foreman

  
Original signed by jurors

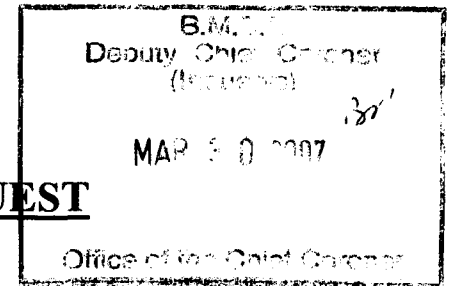
The verdict was received on the **26TH** day of **March** 20 **07**

  
Original signed by Coroner

**RECOMMENDATIONS**  
**TOUCHING THE DEATH OF RINCHEN TSERING KHEDUP**  
March 26, 2007

We the jury recommend that the Ministry of Community Safety and Correctional Services convene a meeting and invite all key stakeholders involved within the “circle of care” of all inmates in custody who are hospitalized, for the purposes of developing a protocol to allow for timely reciprocal sharing of health information.

**VERDICT EXPLANATION**  
**RINCHEN TSERING KHEDUP INQUEST**



March 26, 2007  
Coroners Courts  
Toronto, Ontario

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.

**Summary of the Circumstances**

Rinchen Tsering Khedup was an offender with an extensive criminal history who was admitted to the Metro East Detention Centre on February 15, 2005 and was serving a sentence. He was transferred to the Metro Toronto West Detention Centre (MWDC) on February 24, 2005.

Upon admission, he was administered an Admission Checklist that determined that he was not at risk for suicide. During a previous incarceration in February 2002, he had been assessed and was determined to be at risk for suicide, and had been placed on a suicide watch. For this reason, the institutional physician who assessed him during his current admission at the MTWDC referred him to a psychiatrist. The psychiatrist assessed him on March 3, 2005 and determined that he was not at risk for suicide, and did not require any further psychiatric care. His past medical history revealed that he had suffered a brain injury as a result of a significant assault in the past. He suffered with a resultant seizure disorder for which he took Dilantin, and was a significant substance abuser.

Mr. Khedup was housed in the Special Needs Unit 6A, cell #3. While on patrol on April 12, 2005 at 0147 hours, he was discovered hanging by a ligature fashioned out of torn bed sheets and a towel. This ligature was attached to the cell door. Correctional officers promptly loosened the ligature and cut it. Cardiopulmonary resuscitation was started immediately. Mr. Khedup had a cellmate who reported that he was asleep and did not notice anything unusual.

Fire department personnel arrived at 0206 and assumed care of Mr. Khedup. He was transported by paramedics to William Osler Health Centre, Etobicoke Site, and was admitted to the intensive care unit. He remained in custody in the intensive care unit until his being declared brain dead on April 18, 2005 at 1102 hours.

An autopsy was performed on April 21, 2005. It found the cause of death to be “delayed hanging complicated by bilateral bronchopneumonia”. Of importance, was that the pathologist observed no sign of trauma to his body suggestive of a struggle.

A mandatory inquest was conducted at the Coroners Courts in Toronto pursuant to Section 10(4) of the Coroners Act, which states:

*Persons in custody*

*(4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under section 24.1 of the Young Offenders Act (Canada), whether in accordance with section 88 of the Youth Criminal Justice Act (Canada) or otherwise, the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (4); 2006, c. 19, Sched. D, s. 4 (2)*

Ten witnesses gave evidence over one day, and four items were entered as exhibits. The Jury deliberated for approximately two hours to arrive at its verdict.

**Participants**

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Network Reporting and Mediation  
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**Parties with Standing**

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Dr. Ben Aron

Ministry of Community Safety and  
Correctional Services  
Metro Toronto West Detention Centre

**Counsel**

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416-314-6066

**Cause and Manner of Death**

The Jury found that Rinchen Tsering Khedup aged 25, died on April 18, 2005 at 1102 hours at the William Osler Health Centre, Etobicoke, Ontario. The manner of death was suicide and the cause of death was complications of hanging.

**Recommendations****Ministry of Community Safety and Correctional Services**

We the jury recommend that the Ministry of Community Safety and Correctional Services convene a meeting and invite all key stakeholders involved within the “circle of care” of all inmates in custody who are hospitalized, for the purposes of developing a protocol for timely reciprocal sharing of health information.

**Coroner’s Comments**

Evidence was heard from the superintendent of the Metro Toronto West Detention Centre, that he is tasked with making decisions about human resources for the custody of inmates while in hospital. These decisions might include the granting of temporary leaves of absence for certain offenders for compassionate reasons. Due to a “perception” of restrictions imposed by the Personal Health Information Protection Act (PHIPA), hospital health care providers are reluctant to share any information with staff from the MTWDC. This can result in lengthy delays in decision-making, as accurate helpful medical information is seldom easily forthcoming.

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, M.D., C.C.F.P.

