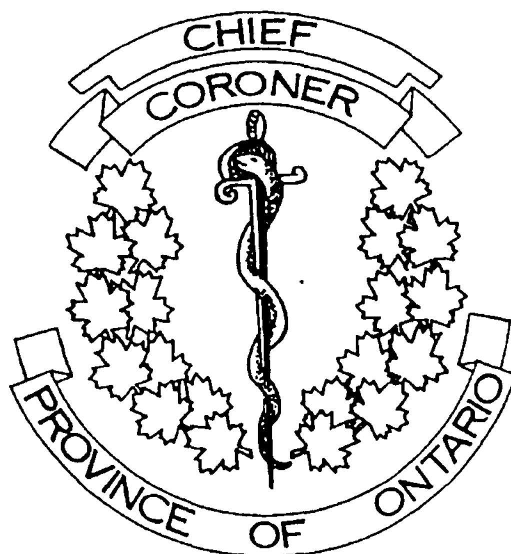

INQUEST

TOUCHING THE DEATH OF

HUGO MANZANO

JURY VERDICT AND RECOMMENDATIONS

March 2000

Ontario

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

We / Nous soussignés,

Lonnie WELLMAN	of / de	Toronto
Alex HUDGIN	of / de	Toronto
Grace HSUEH	of / de	Toronto
Roberto LEDERRI	of / de	Toronto
Hanna LLOYD	of / de	Toronto

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

Surname / Nom de famile: MANZANO

Given names / Prénom: Hugo

Aged / âgé(e) de: 33 yrs.

held at / qui a été menée à: Coroner's Inquest Courts, 15 Grosvenor Street, Toronto, Ontario

on the / le: 14th., 15th., 16th., 17th., 20th., 21st., 22nd., 23rd., 24th., 27th., 28th. day(s) of (du/au) March 2000

by / par: Dr. William LUCAS, Coroner for Ontario / coroner pour l'Ontario.

1. Name of deceased / Nom du (de la) défunt(e): Hugo Emerson Manzano
2. Date and time of death / Date et heure du décès: August 11th. 1999, at 13:42 hrs.
3. Place of Death / Lieu de décès: The Toronto Hospital (Western Division), Toronto, Ontario
4. Cause of death / Cause du décès: Chloral Hydrate (Trichlorethanol) Intoxication
5. By what means / Circonstances entourant le décès: Accidental

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the 28th. day of March, 2000
Ce verdict a été reçu par moi le

Original signed by Coroner

Recommendations are directed to the following parties without priority:

Center for Addiction and Mental Health (CAMH) and Psychiatric Facilities

1, 5, 6, 8 through 25

Department of Ambulance Services

1

General Hospitals

1, 14, 21

Ministry of Attorney General (Ontario)

4, 7, 24, 25

Ministry of Correctional Services

7

Ministry of Health

4, 5, 6, 20, 21, 22, 23

Toronto Police and Other Police Services

2, 3, 4, 7

Jury Recommendations Concerning the Death of Hugo Manzano

The following recommendations are not presented in any particular order of priority.

1. Any patient deemed medically unstable and/or requiring urgent transfer to a hospital for further assessment/medical clearance should be under constant observation by qualified staff, until responsibility for care is assumed by ambulance personnel.

   Rationale: To provide maximum safety and care to patients.

2. The Toronto Policy Service should consider a revision to its Criminal Investigative Processing System (C.I.P.S.), by adding a separate panel entitled "Mental Health Act Contact". The changes to C.I.P.S. should be integrated with the Canadian Police Information Computer (C.P.I.C.) system so that when Mental Health Act forms are executed they are removed from the system.

   Rationale: To eliminate confusion and to provide a more detailed pool of information.

3. The Toronto Police Service should educate and encourage officers in the use of the "Emotionally Disturbed Person" contact form, so that it can serve its intended useful function and provide medical personnel with information concerning the client.

   Rationale: This will provide more detail about the patient. This may assist in the assessment and treatment of the patient.

4. Justices of the Peace should use the current and most up-to-date Form 2 and the Form 2 should be reviewed with consideration given to expanding the factual information provided.

   Rationale: See # 3.

5. The telephone number of the Informant of the Form 2 should be added to the Form 2 and C.P.I.C. screen. The police officer apprehending the person to be examined on the Form 2 should notify the Informant (either from the hospital or from the police station) as soon as possible.

   Rationale: To ensure all concerned parties are informed of the status of the Form 2.

6. The last line of the Form 2 should be revised as follows: "into custody forthwith to an appropriate place for examination by a psychiatrist, or where not available, a physician" as soon as possible.

   Rationale: We feel it is more appropriate for a psychiatrist to examine a patient on a Form 2 since he/she is specifically trained to examine people who are possibly suffering from a mental disorder.

7. Peace officers (parole and probation officers – correctional personnel) should receive, as a regular part of their professional training, current information on community organizations that provide assistance to persons with serious mental health problems and programs where treatment for concurrent disorders or substance abuse disorders is available. In addition, training should include information on organizations that provide information and education to families of persons with serious mental health problems.

   Rationale: To increase overall awareness of resources to all parties involved.

8. Recommend that the Centre for Addiction and Mental Health (CAMH) review the current configuration of the medication room on the Secure Observation and Treatment Unit (SOTU) and consider physically changing the unit. This recommendation should be subject to 2-3 independent security consultants' redesign proposals. CAMH management and staff, collectively, decide on the best configuration and implementation.

   Rational: To ensure the utmost security and safety for both patients and staff.

9. In the interim of having the medication room redesigned, SOTU should consider installing a system on the medication room door, which would sound an alarm if the door was inadvertently left ajar for more than a reasonable period of time to allow the medication nurse to enter or exit.

   Rationale: See # 8.

10. Consider the practicality and desirability of searching all packages into and out of secure units by patients and visitors or request that visitors leave packages at nursing station. As well, visitors should sign in/sign out and at the discretion of the staff, provide ID.

    Rationale: See # 8.

11. Recommend that CAMH complete implementation of a Unit Dose medication administration system as soon as practicable on all units.

12. Install locks on all garbage cans and similar devices in washrooms.

    Rationale: See # 8.

13. Recommend that CAMH review the practices and policies with respect to pharmacy technicians to ensure that there is a uniform system in place of control the use of any stock medications. It is further recommended that a process be in place to ensure that the practices of the pharmacy technicians are in accordance with these policies. This would apply to any units not on unit dose who are using stock medications or for any stock medications that may be used in conjunction with the unit dose medications administration system.

14. Consideration should be given to discouraging patients from being near the medication storage areas on hospital and psychiatric wards. Hospitals and psychiatric wards should review policies, procedures and practices surrounding the dispensing of medication.

    Rationale: See # 8.

15. Recommend that CAMH review the policies that are being developed with respect to the audit of stock medications.

    Rationale: To account for all stock medication dispensed.

16. Pharmacy should attach a delivery slip to a stapled bag of medication for the 3:00 p.m. AMSCAR delivery and ensure that the receiving RN signs the slip for any stock medications received. The signed delivery slip must be returned to Pharmacy for filing.

    Rationale: To increase accountability.

17. Pharmacy should keep a record of requests for stock medication by unit staff, which will include the name of the staff member and request a signature for pick-up or delivery of these medications. File all receiving slips.

    Rationale: See # 16.

18. It is recommended that there should be a minimum of two-thirds (66%) staff on SOTU at all times. Therefore schedules for lunch, breaks, and team reviews should be revised.

    Rationale: To ensure adequate staffing during peak periods.

19. It is recommended that the nurse assigned to Q15 (15 minute interval observation) on SOTU should be solely responsible for Q15, charting their observations and observing camera monitors during the assigned duration.

    Rationale: This will allow proper observation for and contact with patients on Q15. We feel that Q15 should not be compromised by additional duties.

20. Sufficient general medical practitioner staff should be available at all times, including night shifts, to address medical emergency situations that may arise. Duty doctors on shift at night should include at least one general practitioner in addition to a psychiatrist, either physically on site or available on call at designated times.

21. It is recommended that all staff including physicians, psychiatrists, RNs, and RPNs receive ongoing training about best practices in treatment and management of persons with concurrent disorders including a serious mental health problem and an addiction to substances or drug-seeking behaviour.

    Rationale: To keep up-to-date on current methods and treatments.

22. Policies and procedures around medication ordering, delivery, storage and dispensing, to be reviewed and/or implemented at CAMH and in all Provincial Psychiatric Hospitals to ensure consistency and safety. Specifically, a review of the storage of medications should be conducted to ensure that all medications are kept locked up and located where patients cannot access them.

23. Consider and evaluate the merits of implementing a unit dose system in all Provincial Psychiatric Hospitals.

24. A patient advocate from the office of the Psychiatric Patient Advocate office should be afforded the opportunity to make submissions to any Incident Analysis and Review Committee (IARC) investigations which raise issues about patient care, before the IARC completes making its recommendations.

    Rationale: We feel that the Psychiatric Patient Advocate office will act on behalf of the patient in question as in many situations the patient may not be able to act on their own behalf.

25. That all recommendations arising from IARC reports respecting patient care be forwarded automatically to the office of the Psychiatric Patient Advocate.

    Rationale: See # 24.

HUGO EMERGSON MANZANO INQUEST

VERDICT EXPLANATION

Location:	15 Grosvenor Street
Dates of Inquest:	March 14th – 28th, 2000
Coroner's Counsel:	Kerry Hughes
Investigating Officers:	Detective David Needham/Doug Scott Toronto Police Service – 14 Division
Coroner's Constable:	Detective Constable Ernest Drummond Toronto Police Service
Court Reporter:	Liz Ritzer 73 Brooklawn Avenue, Toronto, ON M1M 2P7 Tel: (416) 266-3323

Counsel Representing Parties with Standing:

1. Hugh M. Kelly and Bryan Buttigieg representing Centre for Addiction & Mental Health
2. Renee Kopp representing North York Branson Hospital and Nurse Fern Quint
3. Kate Hughes and Ed Majewski representing Registered Nurses at CAMH
4. Darryl Ferguson and Iain MacKinnon representing Drs. Stein, Posner, Rose, Bhide
5. Anita Szigeti representing Canadian Mental Health Association, Ontario Division
6. Celina Manzano representing Manzano family
7. Andrew J. Heal representing Ministry of Health and Long Term Care

I intend to give a brief summary of the circumstances surrounding Mr. Hugo Manzano's death as well as a brief synopsis of the issues explored at the inquest. Where it is felt to be of potential assistance, I will also comment on my understanding of the reasons behind the jury's recommendations. I wish to stress that it will be 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 they can be better understood. It is not intended to replace the jury's verdict.

Mr. Hugo Manzano was a 33 year old male who was born in El Salvador and came to Canada with his family as a child in 1975. He achieved a Grade 12 level of education and during High School, he became involved with street drugs. He subsequently had a history of involvement with drugs such as marijuana, cocaine and crack, as well as alcohol. He was also known to abuse prescription medications, causing his family increasing concern for his well being.

Mr. Manzano had a history of numerous arrests under The Mental Health Act and he had a minor criminal record. During the month of July 1999, his parents became concerned about his behaviour that was becoming more erratic. On July 24th, they attended at the offices of a Justice of the Peace and obtained a warrant for his arrest under The Mental Health Act. (Form 2)

On July 27th, Mr. Manzano was injured in an altercation, and subsequently taken to hospital by police to obtain medical attention. He refused treatment, and while being driven home in a police cruiser, the police officer became aware of the Form 2 warrant. Mr. Manzano was then arrested and taken to North York General Hospital, Branson site, for assessment. He was examined by a registered nurse who was a member of the Psychiatric Crisis Team. She then discussed her findings with the hospital's on-call psychiatrist, who had previously assessed Mr. Manzano approximately 2 weeks prior. A decision was made that Mr. Manzano was not a threat to himself or to the general public and he was released from the Emergency Department.

On July 28th, police were summoned to a store where Mr. Manzano was causing a disturbance, playing musical instruments and behaving in a bizarre manner. They escorted him out onto the street and sent him on his way. On checking their police CPIC computers, they discovered that there was an apparent outstanding warrant for his apprehension under the Mental Health Act. They therefore re-arrested him and took him to the Centre for Addiction and Mental Health, Queen Street site, for assessment.

Mr. Manzano was showing signs of agitation and was behaving in an aggressive manner that caused concern amongst medical staff. He was subsequently admitted to the Secure Observation Treatment Unit (SOTU) as an involuntary patient. Because he was loud, verbally abusive and aggressive, orders were given to maintain him in four-point restraints and on constant observation. Over the course of the next few days, his aggressive behaviour subsided and he was allowed out of his locked seclusion room, initially in waist-wrist restraints. He continued to make significant progress such that on the 10th of August 1999, he was being considered for discharge within a couple of days.

On the 11th of August, Mr. Manzano was observed during the morning hours to be freely moving about the SOTU ward and visiting the lounge area. Shortly after noon, one of the nurses noted that his speech was becoming slurred and his movements ataxic. The Charge Nurse was notified and physicians were summoned to assess Mr. Manzano. Thinking that he may have suffered an epileptic seizure, a call was placed to 911 and an ambulance requested so that Mr. Manzano might be transferred to hospital for further medical assessment and treatment.

When ambulance personnel arrived, Mr. Manzano was uncooperative, exhibiting agitation and aggression. He refused to get on a stretcher so ambulance personnel requested that police attend to assist in transfer to hospital. Mr. Manzano then requested to go to the washroom, refusing to urinate in a bottle. He was assisted to the washroom by hospital staff, who allowed him the privacy of a cubicle, but kept the washroom door open to allow some degree of observation. Having finished voiding, Mr. Manzano then asked if he could have a moment of privacy in the washroom to pray.

Mr. Manzano's wish for privacy was respected, and he was left alone, briefly, in the washroom. A short time later, a member of staff looked into the room and observed Mr. Manzano drinking from a bottle that he had apparently hidden in the washroom garbage can. This bottle was taken from him and later seized by police. Its contents were discovered to be Chloral Hydrate, a sedative medication. Approximately 200 ml of the contents of the 500 ml bottle were missing.

Mr. Manzano's condition continued to deteriorate, and while he was being transferred by ambulance to the Toronto General Hospital, Western Division, he suffered a cardiac arrest. He received resuscitation measures from those in attendance, but arrived at hospital with vital signs absent. Further resuscitative attempts were unfortunately unsuccessful.

The postmortem examination, including toxicology tests carried out by the Office of the Chief Coroner determined that Mr. Manzano had died as a result of Chloral Hydrate (Trichloroethanol) intoxication.