Ontario

Ministry of the Solicitor General – Office of the Chief Coroner
Ministere du Soliciteur General – Bureau du Coroner en chef.

Verdict of Coroner's Jury/Verdict du jury du Coroner

We Beverley MacInnis

Robert Hamilton

Wilhelmina Braun

Susan Swanzey

Thomas Harvey

the jury serving on the Inquest into the death of:

Surname	Given Names
K	M

aged 17 held at 530 Queensway, West Simcoe, Ontario
on the 14th – 21st day(s) of February 2005
by Dr. David Eden Coroner for Ontario

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

1. Name of deceased M. K.
2. Date and Time of Death October 16, 2003 at 1:39 A.M.
3. Place of Death Norfolk General Hospital
4. Cause of Death Hanging
5. By What Means Suicide

Bev MacInnis
Foreman

Wilhelmina Braun

Robert Hamilton

Susan Swanzey

Thomas Harvey
Signature of Jurors

This verdict was received by me this 21st day of February 2005

Dr. David Eden M.D.
Signature of Coroner

We wish to make the following recommendations:

1. Redesign the desks in each resident's room to eliminate points of attachment for devices such as ligatures – i.e. tubular piping in current design.

   Rationale: Ligature was attached to tubing. Shelves and desk had/have points of attachments.

2. All personnel, including medical and psychiatric involved in the treatment and/or management of residents,
   a) be made fully aware of the Policies and Procedures of the Ministry of Children and Youth Services in regard to residents who are suicidal and the appropriate use of segregation for such situations
   b) and such said Policies shall be reviewed at least once a year.

   Rationale: Inconsistencies in individual understanding of the "Policy and Procedures" of the Institution/Ministry.

3. All persons involved in the treatment and /or management of residents shall be required to take an initial suicide prevention course upon beginning employment at the Correctional Institution followed by a refresher course once a year thereafter.

   Rationale: Some staff could not remember ever taking course.

4. In light of the fact that approximately 30% of the residents at Sprucedale present with apparent mental illness and there appears to be no secure psychiatric facility outside the correctional institution to treat these residents, especially those who have suicidal ideation, we recommend that:
   a. consideration should be given to the setting aside of a number of secure rooms at Sprucedale and that,
   b. these rooms be bright and create a warm friendly atmosphere.

   Rationale: Evidence given, stated 30% of their population have mental health issues. Bright, warm places, etc. are preferred for mental health treatment.

5. All in-house procedures need to be formulated to improve communication amongst staff, i.e. mandatory reading of logbook to insure the timely sharing of pertinent information between staff and / or the various departments.

   Rationale: Doubt raised if everyone always reads log.

6. The Ministry needs to review the available services for young persons suffering from apparent mental illness while in custody so that the institutions like Sprucedale have a ready and seamless method of providing appropriate psychiatric care to the extent it is medically required after the resident is released from custody at the institution.

   Rationale: Adequate services not available on release from custody as per testimony.

7. Encourage random bed checks particularly for those who have ever been on a suicide watch or have been identified as a suicide risk and let all residents know that random checks are the norm.

   Rationale: Random bed checks could prevent a 15 –minute block of time to execute plans.

8. Inquire into the feasibility of intramuscular injection for appropriate medications for residents suffering from apparent mental illness as an option to be available to the medical staff, subject to the consent of the resident.

   Rationale: Would know if medication is taken or refused. Could purge oral medication. May refuse either route of administration.

9. Consider a policy that once a resident is considered a suicide risk, whether they are placed on a suicide watch or not, thereafter in all subsequent institutions they shall be viewed as a person of heightened suicide risk and that staff be made aware of this fact.

   Rationale: Testimony was given that medical record does not go into "OTIS" file. This should be included because of the fluctuating nature of mental illness – i.e. suicide

10. Where a resident arrives with a psychiatric history of self-harm or becomes apparently mentally ill while in custody, consideration be given to obtaining the necessary consents to obtain all past medical records (including family medical records) where feasible.

    Rationale: Family doctor had pertinent information available that was not asked for; consent is needed.

11. The Ministry should develop a policy to ensure that a Doctor of Psychiatry shall be in attendance at least one day a week at Child and Youth Correctional Institutions.

    Rationale: To improve mental health services of residents.

Regional Supervising Coroner
Niagara Region

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February 21, 2005

Dr. Barry McLellan
Chief Coroner for Ontario,
26 Grenville Street,
Toronto, Ontario
M7A 2G9

Re: Inquest into the death of "M.K."
Held in the Simcoe Courthouse
From February 14th to 21st, 2005

Dear Dr. McLellan:

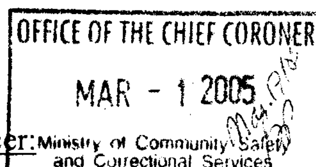
I intend to give a brief synopsis of the issues presented at this Inquest and explain in some detail the reasons for the Jury's recommendations. I would like to stress that much of this would be my interpretation of the evidence and also my interpretation of the Jury's reasons. The sole purpose of this is to assist the reader to more fully understand the Verdict and recommendations of the Jury and is not intended to be considered as actual evidence at the Inquest. It is in no way intended to replace the Jury's Verdict.

The Inquest began hearing evidence on February 21st and heard evidence from 17 witnesses over 5 days, with summation and charge to the jury on February 21st. The Jury returned their Verdict and Recommendations on February 21st, 2005.

As per the provisions of the *Youth Criminal Justice Act*, neither the full name of the deceased nor other identifiers are provided in this verdict explanation.

Participants:

Counsel to the Coroner:	Mr John Ayre
Parties with standing:	
Family of M.K.	Agent, father of M.K.
Attending physicians	Counsel Mr Michael Lehmann
Ministry of Child & Youth Services	Counsel Mr Dennis Brown, Mr James Kendik and Mr James Smith
Investigating Officer:	Det/Cst Richard Dekoninck, OPP
Coroner's Constable:	Cst Eric Deserrano, OPP


OFFICE OF THE CHIEF CORONER
MAR - 1 2005
Ministry of Community Safety and Correctional Services

Court Reporter: Ms Donna Comer
12 Berkley Cres., Simcoe. N3Y 4T4
519-428-0767

The jury heard that M.K. was a healthy and active child, until, at high school age, he began to show changes in behavour, including use of illicit drugs and involvement in property crimes. After several interventions for criminal offences, he was sentenced to 4 months in secure custody at Sprucedale, a secure facility for young offenders located in Simcoe. The staff there included not only corrections officers with specific training and experience with young offenders, but also psychologists, nurses and teachers, as well as visiting medical staff including general practice and psychiatry. Staff had taken courses in suicide awareness, and gave evidence of their application of suicide risk assessment in their interactions with M.K.

Prior to and during his admission to Sprucedale, M.K. exhibited marked signs of psychosis, including hallucinations, delusions, bizarre and inappropriate conduct and speech, and suicidality. He was assessed, and started on medications for treatment of depression and psychosis. Diagnosis in psychiatry can involve repeated assessments and evaluation of response to treatments, and, while he appeared to have responded to treatment, no definitive diagnosis had been made at the time that M.K. died. In retrospect, expert opinion was that he had a schizoaffective disorder, a serious mental illness requiring substantial intervention by skilled mental health professionals.

On the last day of his life, M.K. was active, and denied suicidal intentions on a number of occasions. He was last seen alive at midnight. At about 12:15 am, on a routine check, he was found hanging in his room. Despite aggressive resuscitation initiated by Sprucedale staff and continued by paramedics during transfer to hospital, M.K. was pronounced dead after his arrival at the hospital.

The jury heard that the rooms have since been altered so as to prevent a hanging using the same method.

The jury heard evidence that adolescent psychiatry (of those roughly 12 to 18 years of age) is a recognised subspecialty in psychiatry, and that there are substantial differences in mental disorders in adolescents, as compared to adults. The jury also heard that there is a shortage of physicians in Ontario in many specialties: general psychiatry and, even more so, adolescent psychiatry are particularly underserved: the current number of adolescent psychiatrists is about 1/3 of that required to service basic needs,with the result that waiting lists are typically longer than 6 months. Furthermore, there is not an appropriate mental health facility for the treatment of a mentally ill young offender in secure custody, such as M.K. While Sprucedale appears to have made considerable efforts to address M.K.'s needs within the resources of the facility, the jury heard that his needs might more comprehensively have been addressed in a secure psychiatric facility for adolescents, had one existed.

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Page 2 of Verdict

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    Rationale: To improve mental health services of residents.

I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties and 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 recollection 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 or conclusion of the Jury it will be greatly appreciated if it could be brought to my attention and I will gladly correct the error.

Yours sincerely,

David S. Eden, M.D.
Regional Supervising Coroner Niagara
Presiding Coroner