

INQUEST

TOUCHING THE DEATH OF

SAMUEL JOSEPH PIRRERA

JURY VERDICT AND RECOMMENDATIONS

November 2000



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 the undersigned **Rona Applebaum** of **Toronto**
 Nous soussigné **Nita Cohen** of **Toronto**
Paul Winter of **Toronto**
Lutgardo Reyes of **Toronto**
Arno Koppel of **Toronto**

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 **Pirrer** | Given names / Prénom **Samuel Joseph**

aged **32** held at **the Coroner's Inquest Courts, 15 Grosvenor Street, Toronto, Ontario**
 âgé(e) de qui a été menée à

From the **20th. November** to the **23rd. November** 20 **00**
 du a la

By **Dr. Morton Reingold** 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) **Samuel Joseph Pirrer**
2. Date and time of death / Date et heure du décès **12th. February 2000 at 11:25am.**
3. Place of Death / Lieu de décès **Toronto East Detention Center, Toronto**
4. Cause of death / Cause du décès **Narcotic Toxicity**
5. By what means / Circonstances entourant le décès **Suicide**

Rona Applebaum
 Original signed by: Foreman/Président du jury

Nita Cohen
Paul Winter
Lutgardo Reyes
Arno Koppel
 Original signed by Jurors/Jurés

The verdict was received on the **23rd.** day of **November** 20 **00**
 Ce verdict a été reçu par moi le

[Signature]
 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

RECOMMENDATIONS:

TO: THE MINISTRY OF CORRECTIONS

1. The Admitting Correctional Officer and his or her immediate Supervisor must be responsible to ensure medical personnel are present on ALL admitting inmates. Where an inmate (either a new inmate or a transferred inmate) has a history of mental illness, particularly a history of suicidality, the admitting institution should be required to conduct a medical assessment of that inmate such that the present risk of suicidality is ascertained. This assessment should be carried out on admission or as soon thereafter as is practicable. Further, if, after the initial assessment, the inmate is deemed not to be suicidal and is placed in general population, a reassessment of that inmate for suicidality should occur within a reasonable period of time.
2. Where an inmate (either a new inmate or a transferred inmate) has a history of mental illness, particularly a history of suicidality, this should be noted in a prominent location, in red, on the outside of the inmates file. In addition, a directive should be issued to the effect that when the Admission and Discharge unit of a correctional institution observe such an indication on an inmates file, the medical department of the institution is immediately notified.
3. Where it is known that an inmate has been recently treated by a Psychiatrist, the admitting correctional institution should ensure that the inmate is reassessed by a psychiatrist within a reasonable period of time. Where this prior psychiatric treatment has occurred at a correctional institution, this information should be clearly transmitted to the receiving correctional institute's medical department.

Rationale:

A senior member of the correctional facility must be held accountable that all inmates' medical needs be established, assessed and reviewed. Previous medical assessments should be taken into consideration but not solely relied upon. Inmates potential for suicide should be based on current medical information.

4. The Ministry should adopt a protocol for responding to apparent medication errors and/or discrepancies. Administering and accounting of all medications must be prompt and accurate. A follow up must be made for all unused medications.

Rationale: Medications have become an institutional commodity. To ensure tighter controls protocols must be put into effect.



5. The Ministry should undertake a study of the presence and procurement of illegal and contraband drugs in correctional institutions with a view to reducing or eradicating the problem.

6. We, the Jury, recommend that the Chief Coroner of Ontario provide a progress report on the status of implementation of the recommendations approximately one year after the conclusion of this Inquest.

La
nr

Verdict Explanation

INQUEST TOUCHING THE DEATH OF
SAMUEL JOSEPH PIRRERA

Date of Inquest: November 20-23, 2000

Parties with Standing:

1. The Ministry of Correctional Services
represented by Mr. Brian Whitehead

Counsel to Coroner: Mr. Tom Schneider - Crown Attorney

Investigating Officer: Detective Constable Colin Sinclair

Coroner's Constable: D/C Ernest Drummond

Court Reporter: Ms. Liz Retzer,
73 Brooklawn Ave, Toronto, Ont.,
M1M 2P9
Tel:416-266-3323.

I intend to give a brief synopsis of issues presented at this inquest and explain in some detail the reasons for the jury's recommendations. The jury has included some rationale with their recommendations and anything I add will be to compliment their reasons. The sole purpose for my comments is to assist the reader to more fully understand the verdict and the recommendations of the jury. It is not intended to be considered as actual evidence nor is it in anyway intended to replace the jury's verdict.

The decedent, Mr. Samuel Joseph Pirrera, who had a history of substance abuse, as well as a lengthy criminal record including many drug offences, was arrested on April 3, 1999 on serious criminal charges. He was placed in the Hamilton Wentworth Detention Centre. He was subsequently transferred to the Quinte Detention Centre, where he attempted suicide. He was then being transferred back to Hamilton with a stop-over at the Toronto East Detention Centre (TEDC). He was admitted to the TEDC on February

11,2000, and the next morning, on February 12,2000, he was found deceased laying on his bunk in cell #4231.

An inquest was ordered because the deceased died while in police custody - a mandatory inquest.

At the inquest evidence was heard from several witnesses, including Police, various corrections officers at the TEDC, nursing staff at the TEDC, the patholgist who performed the autopsy on Mr. Pirrera, and the toxicologist. As well, several written documents and physical evidence was presented to the court. In all 36 exhibits were entered into evidence.

Evidence was heard that Mr. Pirrera had attempted suicide on numerous occasions prior to his incarceration at the TEDC, and this information was contained in his inmate file. A document from his medical file showed that he had been treated by a psychiatrist at the Quinte Detention Centre, and placed on a suicide watch for a period of time. Upon his admission to the TEDC, Mr. Pirrera was processed by a corrections officer who had access to his inmate file(which was not highlighted in any way to alert staff to his prior psychiatric/suicidal history), and he was placed in the general inmate population. Also, on admission, his medical file was apparently reviewed by a nurse, but he was not interviewed by the nurse or any other medical staff. On the evening of February 11,2000, a nurse was to have given medication to Mr. Pirrera, but due to an apparent mix-up, he never received his medication, and the error was not followed up that evening. The next morning, during routine nursing rounds, it was discovered that Mr. Pirrera was vital signs absent in his cell. Evidence heard from the pathologist and toxocologist showed that Mr. Pirrera died of narcotic toxicity - he had a massive amount of Morphine in his blood; and there was no evidence to suggest that Mr. Pirrera died of natural causes or due to a homicide.

Verdict:

1. **Name of deceased:** Samuel Joseph Pirrera
2. **Date and time of death:** February 12,2000 at 11:25 hr.
3. **Place of death:** Toronto East Detention Centre, Toronto
4. **Cause of death:** Narcotic toxicity
5. **By what means:** Suicide

RECOMMENDATIONS:

TO: THE MINISTRY OF CORRECTIONS

Recommendation #1:

The Admitting Correctional Officer and his or her immediate Supervisor must be responsible to ensure medical personnel are present on ALL admitting inmates. Where an inmate (either a new inmate or a transferred inmate) has a history of mental illness, particularly a history of suicidality, the admitting institution should be required to conduct a medical assessment of that inmate such that the present risk of suicidality is ascertained. This assessment should be carried out on admission or as soon thereafter as is practicable. Further, if, after the initial assessment, the inmate is deemed not to be suicidal and is placed in general population, a reassessment of that inmate for suicidality should occur within a reasonable period of time.

Coroner's Comments:

Evidence was heard at the inquest that the deceased, despite his extensive history of suicidality and risk factors for suicide, was not assessed by any medical staff on admission to the TEDC to determine his current risk of suicidality. Also, given that a person's risk of suicidality can change over time, it is hoped that reassessments of inmates at risk will lessen the chance of suicidal inmates 'falling through the cracks'.

Recommendation #2:

Where an inmate (either a new inmate or a transferred inmate) has a history of mental illness, particularly a history of suicidality, this should be noted in a prominent location, in red, on the outside of the inmates file. In addition, a directive should be issued to the effect that when the Admission and Discharge unit of a correctional institution observe such an indication on an inmate's file, the medical department of the institution is immediately notified.

Coroner's Comments:

Evidence was heard that despite the deceased's well documented history of suicidality, his inmate file was not clearly highlighted to alert the Admission and Discharge department of same.

Recommendation #3:

Where it is known that an inmate has been recently treated by a psychiatrist, the admitting correctional institution should ensure that the inmate is reassessed by a psychiatrist within a reasonable period of time. Where this prior psychiatric treatment has occurred at a correctional institution, this information should be clearly transmitted to the receiving correctional institute's medical department.

Rationale:

A senior member of the correctional facility must be held accountable that all inmates' medical needs be established, assessed and reviewed. Previous medical assessments should be taken into consideration but not solely relied upon. Inmates potential for suicide should be based on current medical information.

Coroner's Comments:

Despite the fact that the deceased was recently assessed by a psychiatrist (at the prior correctional institute) with respect to suicidality, no follow-up psychiatric assessment occurred on admission to the receiving correctional institute. The jury wished to emphasize that in the future such assessments would help to ensure that a current evaluation of psychiatric illness and /or suicidality is performed.

Recommendation #4:

The Ministry should adopt a protocol for responding to apparent medication errors and/or discrepancies. Administering and accounting of all medications must be prompt and accurate. A follow up must be made for all unused medications.

Rationale: Medications have become an institutional commodity. To ensure tighter controls protocols must be put into effect.

Coroner's Comments:

Self-explanatory.

Recommendation #5:

The Ministry should undertake a study of the presence and procurement of illegal and contraband drugs in correctional institutions with a view to reducing or eradicating the problem.

Coroner's Comments:

Evidence was heard that the decedent died of a massive drug overdose(narcotic toxicity); and routes by which drugs are obtained and hidden by the prison population was described. The jury was indicating its desire to have the drug issue reviewed.

Recommendation #6:

We, the Jury, recommend that the Chief Coroner of Ontario provide a progress report on the status of implementation of the recommendations approximately one year after the conclusion of this Inquest.

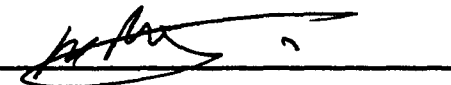
Coroner's Comments:

Self-explanatory.

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's verdict. It is worth repeating that it is not the verdict. This is my personal recollection of the evidence and may be different from the actual evidence. If any party feels that I have made a gross error in my recollection of the evidence or the intent of the jury's recommendations, they may wish to bring it to my attention.

Submitted by: Dr. Morton J. Reingold
Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario
M7A 2G9

Signature



Date: November 27, 2000.