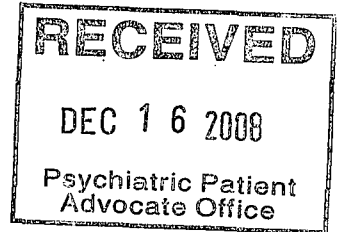




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December 12, 2008

Mr. Ryan Fritsch
Counsel
Psychiatric Patient Advocate Office
55 St. Clair Avenue West
Box 28, Suite 802
Toronto, Ontario
M4V 2Y7

Dear Mr. Fritsch:

Re: Inquest into the death of Clifford Neal Pugh
deceased July 9, 2007. Our file number Q2008-56

Please find enclosed a copy of the Coroner's verdict explanation, verdict, and recommendations of the Coroner's jury from the inquest into the death of Clifford Neal Pugh. We are also including an attachment indicating the recipient that has been asked to respond to the recommendations.

As you represented a party with standing, the above material is being sent to you for your information.

Yours truly,

Andrew L. McCallum, MD, FRCPC
Chief Coroner for Ontario

ALM:pc
Encl.

FOR IMPLEMENTATION:

**Administrator, Oak Ridges Site, Penetang Mental Health Centre,
Ministry of Health and Long-Term Care, 500 Church Street,
Penetang, Ontario L9M 1G3
(Recommendations – 1 to 6)**



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

P.W.

of
de

Horseshoe Valley, Ontario.

J.B.

of
de

Barrie, Ontario.

P.A.

of
de

Angus, Ontario.

M.C.

of
de

Orillia, Ontario.

M.A.

of
de

Utopia, 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

PUGH

Given names / Prénom

Clifford Neal

aged **69**
âgé(e) de

held at **Provincial Court House, Midland, Ontario**
qui a été menée à

from the
du

29th

to the
à la

31st October

20 08

By
Par

Dr.

Savage

Coroner for Ontario
coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following: / avons enquêté at avons déterminé ce qui suit:

1. Name of deceased Nom du (de la) défunt(e)	Clifford Neal Pugh DOB: Apr. 9/38
2. Date and time of death Date et heure du décès	July 9, 2007
3. Place of Death Lieu de décès	Huron District Hospital - Midland, Ontario
4. Cause of death Cause du décès	Choking on Food
5. By what means Circonstances entourant le décès	Accident

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

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

31

day of

October

20 08

Original signed by Coroner

JURY RECOMMENDATIONS

1. **Education:** All staff should receive training/education on dysphagia to reduce risk of choking. Ongoing discussion and training should be incorporated for all staff. This might include basic anatomy of mouth, throat and lungs, role of texture, position of food, posture while eating, oral hygiene and behavioral insight.
2. **Food Service:** It is recommended that the Mental Health Centre Penetang (Oak Ridge Division) create a policy to ensure that all food served at special events (i.e. BBQ) complies with current diet requisition orders for the patients attending such events.
3. **Communication:** An internal audit on dietary risks to be carried out on the flow of patient information (oral and written) to all employees of the Mental Health Centre Penetang (Oak Ridge Division). This audit should verify the proper flow of information. It's critical that this audit also verify the flow of oral information on a patient to all employees. Explore the creation of a new form which would be the lead document on the clinical file and it would be policy for all employees to review all patients on the floor that they are working on at the beginning of their shift.
4. It is recommended that the Mental Health Centre Penetang (Oak Ridge Division) establish a team with appropriate expertise to identify patients with dysphagia, to devise strategies on an ongoing basis to reduce choking and/or aspiration risks in those patients and to ensure that the identification and strategies are clearly communicated to all staff attending to those patients.
5. **Diet:** Lead Dietician should list types of diets available and a clear definition of each diet. This shall be implemented by all departments.
6. **Adequate Staff to Supervise:** It is recommended that where a patient who is at particularly high risk of choking as determined by the dysphagia team and which patient is required to eat alone in his room, the Mental Health Centre Penetang (Oak Ridge Division) fund nursing staff to observe that patient on a one-to-one basis while he eats.

Received by the Office of
Dr. Sandra Penner
Deputy Chief Coroner - Inquests
DEC 5 - 2008

Verdict Explanation

Inquest of Clifford Neal PUGH
Inquest Date: October 29, 30, 31, 2008
605 Yonge Street
Midland, Ontario

Opening comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

Participants:

Counsel to the Coroner: Kevin Sisk, Assistant Crown Attorney
Barrie Courthouse
114 Worsley Street
Barrie, ON
L4M 1M1
705-526-6459

Investigating Officers: Constable Claude Dugay
Badge 12270
Ontario Provincial Police,
South Georgian Bay
16864 Highway 12, Box 250
Midland, ON L4R 4K8
705-526-3761

Coroner's Constable: Constable Susan Fagan
Badge 8086
Ontario Provincial Police
South Georgian Bay
16864 Highway 12, Box 250
Midland, ON L4R 4K8
705-526-3761

DIRK HUYER, M.Q.
REGIONAL SUPERVISING CORONER
DEC 04 2008
GUELPH OFFICE
CENTRAL REGION

Court Reporter:

Bonnie vanGeene, C.C.R.
Legal Reporting Services
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Barrie, ON L4N 6T3
705-722-4806

Parties with Standing:

Ministry of Health and Long-
Term Care

Represented by

Beth Beattie, Counsel
Ministry of the Attorney General
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Psychiatric Patient Advocate
Office

Ryan Fritsch, Counsel
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416-327-7002

Summary of the Circumstances of the Death

This inquest was a discretionary inquest into the death of Mr. Clifford Pugh. This gentleman was an involuntary psychiatric patient at the Mental Health Centre Penetanguishene, Oak Ridge Division. The Jury heard evidence concerning Mr. Pugh's general health and evidence with regard to his eating habits and the difficulties he had with eating. The Jury heard evidence concerning a choking spell he had several weeks before his death. Evidence was presented that changes were ordered for his diet and that individual health teaching had been provided. Evidence was provided about events that occurred on the day he died from choking while consuming food. The jury heard that on the day of his death, there was a barbecue that was provided for the ward patients. His dysphagia diet was not provided at the barbecue.

The jury heard witnesses from the Mental Health Centre Penetanguishene, Oak Ridge Division including the head nurse and program director. They indicated that at the time of Mr. Pugh's death, staff had been trained in the treatment of choking but had little education about the mechanism of dysphagia and the ways to prevent choking. They indicated that patients were monitored while eating but reported staff limitations prevented one-to-one nursing at times. Evidence was provided by a dietitian and supervisory staff in food service at the Mental Health Centre Penetanguishene about the

dietary approaches both at the time of Mr. Pugh's death as well as changes since the death. Since the death measures have been introduced to undertake patient assessments with focus to monitor those at risk for choking as well as choking prevention.

The jury also heard evidence from a speech language pathologist who provided expert testimony about swallowing and dysphagia. This expert discussed the value of swallowing assessments and need for dysphagia dietary approaches.

In total there were 8 witnesses, with 12 exhibits provided for consideration by the jury. The inquest lasted for 3 complete days.

VERDICT OF CORNER'S JURY

Name of Deceased: **Clifford Neal PUGH**
Date of Death: **July 9, 2007**
Place of Death: **Huron District Hospital, Midland, Ontario**
Cause of Death: **Choking on Food**
By What Means: **Accident**

Recommendations:

The jury made 6 recommendations.

Recommendation #1

All staff should receive training/education on dysphagia to reduce risk of choking. Ongoing discussion and training should be incorporated for all staff. This might include basic anatomy of mouth, throat and lungs, role of texture, position of food, posture while eating, oral hygiene and behavioural insight.

Coroner's Comments:

The Jury heard evidence throughout the Inquest indicating that education and training was provided to Oak Ridge Staff for the treatment of choking and remedies for the acutely choking patient. Evidence was heard that ongoing education into strategies that could prevent choking in the aging population of the Oak Ridge Division of the Mental Health Centre Penetanguishene would likely be beneficial.

Recommendation #2

Food Service: It is recommended that the Mental Health Centre Penetang (Oak Ridge Division) create a policy to ensure that all food served at special events (i.e. bar-b-q) complies with current diet requisition orders for the patients attending such events.

Coroner's Comments:

The Jury heard evidence that patient's in the Oak Ridge Division of the Mental Health Centre Penetanguishene were served food in a different manner when they attended special events such as ~~barbecues~~. The Jury felt a policy was required to ensure that staff in charge of patients clearly understood the current diet requisition/diet order for each individual patient so that patients would be served their appropriate diet (the correct food size and consistency) no matter what activity or special event a patient was involved with.

Recommendation #3

Communication: An internal audit on dietary risks, to be carried out on the flow of patient information (oral and written) to all employees of the Mental Health Centre Penetang (Oak Ridge Division). This audit should verify the proper flow of information. It's critical that this audit also verify the flow of oral information on a patient to all employees. Explore the creation of a new form which would be the lead document on the clinical file and it would be policy for all employees to review all patients on the floor that they are working on at the beginning of their shift.

Coroner's Comments:

The Jury heard evidence that documentation indicating dietary risks was accessed from several areas in patient's documentation(i.e. chart, Cardex) and through verbal reports. The Jury felt that this information should be documented on a form that could be readily available for review by staff members at the beginning of their shift. The Jury felt the system of communication with regard to diet and dietary risks should be audited and collected onto a document on the patient's clinical file that would allow a fulsome information source

Recommendation #4

Continuous Patient Review: It is recommended that the Mental Health Centre Penetang (Oak Ridge Division) establish a team with appropriate expertise to identify patients with dysphagia, to devise strategies on an ongoing basis to reduce choking and/or aspiration risks in those patients and to ensure that the identification and strategies are clearly communicated to all staff attending to those patients.

Coroner's Comments:

The Jury heard evidence indicating that the Mental Health Centre Penetanguishene, Oak Ridge Division has established more frequent assessments and increased awareness of dysphagia since the death. In addition there has been knowledge enhancement about the factors, which signal a choking risk. The Jury felt a team should be established with appropriate expertise to identify patients with potential dysphagia or choking risk with goal to devise strategies to prevent choking and aspiration risk. They felt this should be done on an ongoing basis. The report of this team should be clearly communicated to all attending staff and that this team should have a role in staff education.

Recommendation #5

Diet: Lead Dietician should list types of diets available and a clear definition of each diet. This shall be implemented by all departments.

Coroner's Comments:

The Jury felt there was confusion in terminology utilized for the types of diets available. The Jury noted inconsistency in terminology used by the expert witness in contrast to terminology used by the Mental Health Centre staff. It was felt that consistent terminology should be used for description of diets to indicate the type of diet including the diet consistency.

Recommendation #6

Adequate Staff to Supervise: It is recommended that where a patient who is at particularly high risk of choking as determined by the dysphagia team and which patient is required to eat alone in his room, the Mental Health Centre Penetang (Oak Ridge Division) fund nursing staff to observe that patient on a one-to-one basis while he eats.

Coroner's Comments:

The Jury felt that when a patient is identified as being at high risk of choking by the appropriate dysphagia team, and if the patient is required to eat alone in his room the patient should be supervised on a one-to-one basis during the meal. This recommendation was for the Mental Health Centre Penetanguishene to fund nursing staff to provide for one to one observation of such patients while eating alone.

Closing comment:

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 this 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 made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.



Dr. Peter Savage
Presiding Coroner

November 10, 2008