BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.: 2013:0376:0134

An Inquest was held at The Burnaby Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates June 23rd - June 27th 2014

before Dr. D. Kelly Barnard, Presiding Coroner,

into the death of FAST David Edwin 55 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: July 27 2013 at 23:16

Place of Death: Royal Columbian Hospital (Location) New WESTMINSTER (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Diabetic Ketoacidosis

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☒ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 27th day of June AD, 2014.

Dr. D. Kelly Barnard
Presiding Coroner's Printed Name

Presiding Coroner's Signature

FAST	David Edwin
Surname	**Given Names**

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Dr. D. Kelly Barnard

Inquest Counsel: Rodrick MacKenzie

Participants/Counsel:
BC Corrections/Pamela Manhas

Dr. Khan, Dr. Lilla, Dr. Haq, Dr. Severin,
Dr. Rosenczweig, Dr. Schlagintweit/David Pilley

Fraser Heath Authority/Adam Howden-Duke

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded fifteen exhibits. Thirty-three witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The purpose of the summary is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

The jury heard from his care providers that Mr. David Edwin Fast had a complex history of medical, psychiatric and behavioural issues including: poorly controlled type 1 diabetes mellitus from the age of thirteen, chronic obstructive lung disease, ischemic cardiomyopathy, coronary artery disease with a coronary artery bypass in 2004, peripheral vascular disease with a right lower extremity amputation, hepatitis C, cirrhosis, parietal lobe stroke. He also had a long history of psychiatric illness with a variety of diagnoses over the years including: depression with psychotic features, paranoid schizophrenia, substance use disorder, intermittent explosive disorder, and a range of personality disorders. He had been hospitalized at Riverview Psychiatric Hospital and at Colony Farms Forensic Facility in the early 1980's. He was sporadically under the care of community mental health and addictions services as he moved between communities in British Columbia. Following the below-knee amputation of his right leg, and an episode of hyperglycemia and dehydration related to self-reported neglect of his health and non-compliance with medications in 2008, he continued to smoke heavily but abstained from alcohol and illicit drugs.

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In the year prior to his death Mr. Fast's already significant medical and psychiatric care needs increased and necessitated prolonged periods of hospitalization. His inability to manage his diabetes in the community was evidenced by multiple episodes of high and low blood glucose requiring emergency room visits. On October 16, 2012 he suffered an injury on a ramp at his rooming house sustaining a head trauma and injury to his right shoulder. He was initially admitted to the intensive care unit (ICU) at Chilliwack General Hospital (CGH) where his recovery was complicated by prolonged recurrent delirium, multiple episodes of high and low blood glucose (despite intensive management), as well as urinary and skin infections. A CT scan revealed evidence of cerebrovascular disease. His behavior became increasingly erratic through this time with acts of verbal and physical aggression towards care staff, including the uttering of violent threats and an episode during which he was reported to have thrown boiling water at a nurse. These incidents resulted in CGH staff taking complaints to Chilliwack RCMP and crown counsel approved charges. A court appearance was scheduled for August 2013.

One of the psychiatrists providing care to Mr. Fast during his stay at CGH testified that the diagnostic formulation was challenging given the patient's medical problems and intermittent delirium. It was the psychiatrist's assessment that there was no evidence of active psychosis and that the most likely diagnosis was intermittent explosive disorder, a rare condition best treated with a combination of behavioural and pharmacological strategies.

A consulting neuropsychologist reported on her assessment of Mr. Fast on January 23, 2013. She had been consulted to provide an opinion as to his cognitive status, to help ascertain whether he was competent to make his own health care decisions. She explained that neuropsychological testing provides more sensitive and specific assessment of a patient's ability to function than the usual screening tests administered by physicians. Mr. Fast refused to fully cooperate with the examination, thus limiting the testing. She was however able to test sufficiently to provide the opinion that his behavior was strongly suggestive of executive dysfunction and that he suffered "deficits consistent with a diagnosis of dementia due to multiple causes – traumatic, alcohol, and strategic vascular lesions."

One of the social workers involved in the multi-disciplinary care of Mr. Fast in CGH testified that discharge planning for him was particularly challenging due to his high daily medical and nursing care needs, behavioural issues, reliance on a wheelchair, tobacco dependence, and financial concerns. She stated that there were no facilities in the community that could appropriately meet his needs. This was corroborated by his family physician who confirmed the challenges of managing Mr. Fast's medical conditions in the community.

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During his time at CGH a consultation was provided by a Fraser Health clinical ethicist to assist the care team in safely supporting Mr. Fast's care. A Clinical Nurse Specialist was also consulted with respect to the use of the Adult Guardianship Act, which, based on a review of the records and discussions with staff, she deemed appropriate for Mr. Fast. The Clinical Nurse Specialist then completed this certification under Section 59(2) (e). Neither of these consultants met directly with Mr. Fast or his family. His status under the Adult Guardianship Act was reassessed in February by the care team who felt it to no longer apply; however, there was no documentation that Mr. Fast's status under the act was formally rescinded. The decision was then made to arrange his transfer to the Timber Creek Tertiary Care Facility. Admission to Timber Creek requires that patients are certified under the Mental Health Act and this certification was put in place to allow the transfer.

Mr. Fast was at the Timber Creek Tertiary Care Facility between May 3rd and July 17th, 2013. His stay was complicated by episodes of medical instability due to his diabetes, which was difficult to adequately control even in hospital and necessitated transfer to acute care at the adjacent Surrey Memorial Hospital. An endocrinologist was consulted in his medical care on July 2, 2013 during one of these exacerbations. She testified that in addition to his other medical conditions, Mr. Fast had very brittle diabetes, a condition seen in approximately 1 % of Type 1 diabetes patients. These patients require very close monitoring and multiple daily adjustments of insulin dosages. It was her opinion that Mr. Fast was not capable of safely managing his complex diabetic care without assistance and absolutely would not be able to manage if he was in a shelter or was homeless. She also testified that Mr. Fast was in danger of acute complications of diabetes including ketoacidosis and death if he did not receive his insulin.

The social worker involved in Mr. Fast's care team at Timber Creek testified that he appeared to lack insight about his illnesses and in her opinion was not capable of caring for himself. She repeated the significant safety concerns in discharge planning with no facilities suitable to meet his complex needs since the closure of the specialized facilities at Riverview Hospital. The Patient Care Manager at Timber Creek and the Director of Tertiary Mental Health Services for Fraser Health both testified as to the complexity of Mr. Fast's case and the extensive meetings and consultations regarding the planning of his care. These sessions were not documented. Much of the concern focused on the question of his competence to make his own decisions regarding his care given his behavioural outbursts and extreme vulnerability due to his medical conditions. Peterson Place was identified as a possible option for him as a low barrier housing facility where additional home support could be provided to help with his medical care. The plans for this placement were not completed at the time of his discharge.

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The attending psychiatrist at Timber Creek presented evidence by deposition and telephone follow up. He stated that Mr. Fast was initially admitted under the provisions of the Mental Health Act but that this certification was not renewed on its expiry on June 30, 2013. It was his opinion at that time that Mr. Fast was not suffering from a major mental illness, was not psychotic and that his most likely diagnosis was Intermittent Explosive Disorder, which in his opinion did not constitute a condition necessitating holding Mr. Fast under the Mental Health Act. His treatment recommendations included behavioural management and some low dose antipsychotic medication. After the lapse in this certification Mr. Fast remained at Timber Creek as a voluntary patient. This stay was complicated by many angry confrontations with staff, largely with respect to restrictions on his smoking based on the rules of the facility. The psychiatrist testified that there were many case conferences regarding the care of Mr. Fast, and that the care plan included calling the RCMP to attend the hospital ward and warn Mr. Fast to modify his behavior.

On July 12, 2013 Mr. Fast discharged himself against medical advice. While waiting outside the hospital for a ride, one of the staff was able to convince him to return to the hospital for care.

On July 17, 2013 it was reported that Mr. Fast had become extremely agitated and was flailing his arms at staff. The psychiatrist was called and advised by telephone that the RCMP should be called. The officer who attended refused to take Mr. Fast into custody as he felt that he "would not survive in a police cell" as there was not adequate medical attention. The psychiatrist was contacted again by telephone by the hospital staff and he advised them that if Mr. Fast wished to take his own discharge then he should be allowed to do so. It is not clear what if any possessions, medications, or diabetes monitoring supplies Mr. Fast took with him when he left the facility. He was apparently in his wheelchair and was given a shelter list by hospital staff.

Mr. Fast was dropped off at the Gateway of Hope Shelter in Langley by the RCMP late in the afternoon of July 17th. There he was noted by shelter staff to have open bleeding skin lesions and no medications, insulin, or supplies. At 9:30 that evening he asked that an ambulance be called as he needed to go to hospital to get insulin or he would, "go into a coma." The ambulance transported him to Langley Memorial Hospital (LMH) at 10:20 pm.

On admission to the emergency department at LMH on July 17th at 10:30 pm he was found to have a high blood glucose and associated metabolic abnormalities. He was kept in the emergency department for treatment. During the stay an assessment was performed by a psychiatrist. This psychiatrist testified that he found Mr. Fast to be competent to make his own medical decisions at this time and thus could not be kept under the Mental Health Act. A social worker at LMH assessed Mr. Fast finding him to be a vulnerable adult in need of complex care, and was concerned about his safety were he to be discharged from the hospital. She reported that Mr. Fast agreed that Peterson Place would be a good option for him and that he was willing to go there. The social worker ascertained that a full application had not been

completed for Peterson Place and she undertook to follow up on that application, however he again discharged himself before those arrangements could be finalized.

On July 23rd, 2013 an emergency room physician was called to attend Mr. Fast after an episode of verbal aggression directed at staff in the emergency department. She reviewed his medical condition, the psychiatric consultation and acquiesced to his decision to discharge himself, despite the ongoing risk. She provided him a written prescription for his medications and he was also given a taxi voucher. It was her understanding that he was going to return to the Gateway of Hope Shelter.

There is no indication of where Mr. Fast went on July 24th. There is no record of his attendance at a shelter. There is indication in the Pharmanet records that Mr. Fast filled a prescription for insulin on July 24th, 2013 at a Chilliwack pharmacy with the prescribing doctor recorded as his family physician. No other medications were dispensed.

On the morning of July 25th at 6:29 am Mr. Fast was picked up by the Chilliwack RCMP on a street corner and brought to the jail in Chilliwack based on his outstanding warrant for uttering threats. He had a wheelchair and a bag with a cookie, but no medications, insulin, or diabetes testing equipment. While in cells the constable reported that Mr. Fast complained that he was very thirsty, and stated that he required assistance to get water from the tap. He was noted to be gulping water and he vomited once. He was also incontinent of urine. He was taken by the Sherriff's Service to Chilliwack Court where he was held on remand for a psychiatric assessment and to be returned for a court appearance the next day. He was then transferred to North Fraser Pretrial Facility (NF).

At 8:16 pm Mr. Fast was brought before a registered nurse who was designated to do his medical intake assessment at NF. She noted him to be uncooperative and yelling and screaming, and she did not do any assessment of him. It was also noted that he could not be assessed by the psychiatric intake worker as "he couldn't follow simple direction and wasn't making sense while speaking." She recommended that he be placed in the segregation unit on a suicide protocol with checks every fifteen minutes, and that the medical and psychiatric intake be completed the next day. No medical conditions or medication requirements were noted in the record at that time.

On July 26th Mr. Fast was scheduled for transfer to the Chilliwack Courthouse. A Deputy Sherriff encountered Mr. Fast at 8:10 am. He testified that Mr. Fast was in a wheelchair with no sock or shoe on his remaining leg which was swollen and purple, and he was unable to bear weight without assistance. The DS felt that Mr. Fast was not well enough to be transported and asked if the appearance could be conducted by video. He was told by the Acting Sergeant that this was not possible. Mr. Fast told the DS that he was a diabetic and that he required his medication, This was reported to the A/Sgt. who checked with the records department of NF and was informed by them that there was no record of Mr. Fast being a diabetic and that no medications were ordered. The medical staff also "cleared him for transport" over

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the phone. The DS reported that Mr. Fast was excessively drowsy and would drift off to sleep in his wheelchair. Even with support Mr. Fast could not be transferred into the transport vehicle. Finally the DS, who felt that Mr. Fast was too ill, refused to transport him. Mr. Fast appeared by video conference later that morning and was again remanded in custody for psychiatric assessment.

That afternoon at approximately 2 pm Mr. Fast was assessed by a Registered Psychiatric Nurse. Her notes describe him as "lethargic, drowsy, uncooperative" although he did sign a release form permitting her to access the Pharmanet records (a history of all medications dispensed to him from community pharmacies). It is important to note that these records do not contain information regarding medications given in hospital. She noted from those records that the drug list included insulin. Her visit record indicates a blood pressure of 100/60, a pulse of 72 beats per minute with the other vital signs noted as "refused." She also did a blood glucose measurement using a portable glucometer device and recorded the reading as 5.2 mmol/L, which is in the normal range. This finding is out of keeping with what would have been expected based on testimony regarding his medical condition and subsequent events. When questioned as to whether he was "hearing voices" or had thoughts of harming himself she reported that he answered in the affirmative. He was therefore kept in the segregation unit under observation every 15 minutes.

Shortly after this assessment Mr. Fast was also assessed by the physician on duty. His notes describe Mr. Fast as "uncooperative, slurred speech, ornery and potty mouthed." The physical findings noted were: blood pressure of 80/60, chest clear, heart sounds normal, left foot cool, poorly perfused. The doctor testified that on review of the Pharmanet records he noted the insulin and attempted to contact the family doctor. He reached a doctor who stated that he had no knowledge of the patient. Mr. Fast's family doctor testified that he did not receive a call from NF and that people frequently confused him with another family doctor of the same name. The doctor at NF did note insulin dependent diabetes, but not what type. Based on his assessment and the blood glucose noted by the nurse the plan was to measure the blood glucose prior to meals and reassess the next day. All medications were held pending that further testing. No testing was done that evening.

Further testimony was presented by correctional officers (CO) assigned to the segregation unit that day and evening. None of the officers on duty on the day and evening of July 26th recalled Mr. Fast. They reported that their usual procedure was to check for breathing and movement on their rounds every 15 minutes. The CO who was on the overnight shift from July 26th until the morning of July 27th remembered Mr. Fast moaning and talking in his sleep through most of the night.

CO's on duty the next morning testified that they attended with the Registered Nurse during rounds at 8:00 am when Mr. Fast was observed from the doorway of the cell, no physical assessment or vital signs were undertaken. The CO noted that Mr. Fast appeared to be very lethargic and minimally responsive to voice commands. Blood glucose monitoring had been ordered prior to meals but as this was the

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weekend, and the morning meal is not served until mid morning, a blood glucose level was not obtained until 10 am. At that time it was recorded as > 35 mmol/L a critically high reading. The doctor was called and arrived to assess the patient at approximately 11:00 am. At that time, the doctor found Mr. Fast to be minimally responsive and considered the possibility of diabetic ketoacidosis. The ambulance was then called. They arrived at 12:20 and within 10 minutes Mr. Fast had suffered cardiac arrest. Basic CPR was begun and an Advanced Care Life Support crew arrived at 12:45 to begin advanced measures, including intubation, parenteral insulin, and multiple rounds of cardiac drugs. A pulse was obtained for a time, but by his arrival at Eagle Ridge Hospital he was again in full arrest. The lengthy resuscitation continued until he eventually maintained a pulse, almost a full 2 hours from the initial arrest. He was transferred to Royal Columbian Hospital to the Intensive Care Unit. The attending Intensive Care Unit (ICU) physician testified that on arrival (after the administration of large amounts of fluid, and insulin therapy during the resuscitation at ERH), Mr. Fast was still unresponsive, required mechanical ventilation, was severely dehydrated and acidotic, and had an extremely high blood glucose reading (63.2mmol/L). Despite maximal medical therapy his condition did not improve and, after consultation with his family, comfort measures were initiated. He died that evening at 23:16 hours eleven hours after his initial cardiac arrest.

An autopsy was performed and the pathologist testified that post mortem examination of the kidney revealed microscopic changes called Armanni-Ebstein lesions, typically associated with severe acidosis. Examination of the vitreous fluid confirmed the presence of ketones. The other pathological findings were in keeping with the known widespread severe atherosclerotic cardiovascular disease and evidence of chronic changes in the kidney and liver associated with diabetes . The small lesions in the brain that had been noted on imaging were confirmed on autopsy. The pathologist concluded that the cause of death was diabetic ketoacidosis.

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Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To the Minister of Justice:

1. Obtain a formal external review of the quality of health care provided in provincial correctional institutions.

2. Institute a policy which states that all individuals being detained must be medically assessed by the local health authority or BC Ambulance Service prior to detention. Where such persons are found to require medications and ongoing medical treatment all efforts shall be made to have medical records released and accompany the individual to holding facility.

   Coroners Comments:
   Evidence was presented that medical assessments were incomplete during provincial custody and were hampered by lack of access to medical records from outside the institution resulting in the the ommission of necessary treatment.

3. Institute a policy requring the assessment and documentation of an inmate's ability to access water and food in the setting of their incarceration on intake and at least every 12 hours during their detention where there are indications of a disabling condition.

   Coroners Comments:
   Mr Fast was noted to require assistance to get water during his brief period at the Chilliwack cells. As he was wheelchair dependent and detained without his wheelchair in the segregation unit of North Fraser Pretrial, he would not have been able ambulate sufficiently to access the food or water in his cell. There were no records pertaining to his intake of food or water and the videotape of his detention was not retained. None of the corrections officers could recall assisting him to obtain water or whether his food was consumed.

4. Develop clear delineation of roles and responsibilities of correctional officers and contracted health care providers and the specific mechanisms for communication between them, including information sharing of any critical physical or mental health conditions.

   Coroners Comments:
   The jury heard that there was no direct sharing of written information between the health care providers and the correctional officers .

5. Implement mechanisms to immediately identify inmates with serious medical and or psychiatric problems so that they can be managed in a suitable setting.

6. Ensure that the contracted health service provider confirms competence in all staff in the appropriate assessment, management and follow up of agitated inmates.

   Coroners Comments:
   Care providers testified that medical and psychiatric assessment of Mr Fast was not completed due to his agitated state. As this behaviour may be due to critical medical and psychiatric conditions requiring immediate medical attention, medical and nursing staff and facilities available for the initial assessment of these inmates must be sufficient to deal with these inmates or arrangements be made immediately available for their transfer to a facility that can provide the necessary asseessment.

7. That any internal reviews of deaths in custody include examination of all records and interviews of all staff and contractors involved in the custody of the deceased inmate.

8. Instruct BC Corrections that all records and statements pertaining to an inmate who dies in custody must be gathered and preserved until all proceedings have concluded.

   Coroners Comments:
   The investigation of this death conducted by BC Corrections involved review of only some of the records available; no staff interviews were conductd. By the time of inquest many staff could not recall the events in the days prior to death and many of the records including surveillance videotapes were no longer available.

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To the Ministers of Health and Justice:

9. Explore proividing health services in BC Corrections facilities through a Health Authority.

   Coroners Comments:
   It was explained that health services are currently provided through a contracted agency. Health authorities have a number of structures and processes for quality assurance that are not available in this stand alone agency, including participation in a national accreditation program, a credentialling process for physicians, and ongoing on-site quality and safety reviews. Additionally, there was testimony of significant impediments in the transfer of information between the health authority and the contracted health staff that in this case resulted in the failure to identfy critical treatment requirements.

10. Review the practice of involving police in the ongoing care plans of hospital inpatients.

    Coroners Comments:
    While at Chilliwack General Hospital the RCMP were actively involved in case discussions and management. The care staff at Timber Creek Tertiary Care facility testified that the care plan for Mr. Fast explicitly included a plan to call the RCMP to the hospital to speak to Mr. Fast when he became violently agitated .

To the Minister of Health and each of the Health Authorities:

11. That guidelines and education on the application of the Adult Guardianship Act and the Mental Health Act be provided to all health practitioners whose responsibilties involve the care of vulnerable adults. This must include clear processes, including documentation for the initiation, continuation and discontinuation of the application of the provisions under these statutes. In particular, any person signing a certificate under these statutes must have directly assessed the patient, communicated the plans and, whenever possible, involved the family.

    Coroners Comments:
    Testimony was presented that there was much debate and some disagreement amongst care providers about the application of these legal provisions in the ongoing care of Mr. Fast. In particular the process for the cessation of the use of these was unclear. These deliberations included a Clinical Ethics consultation that focused on the needs of staff and did not involve direct communication with Mr. Fast or his family. The communication of the potential uses and implication of these legal restrictions to the patient and the family was not well documented.

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12. Consider the implementation of a process to assign a continuing case manager for patients with complex medical and or psychiatric conditions whose care involves multiple services and providers and sites of care including the communtity.

    Corones Comments:
    Many care providers and facilities were involved in Mr. Fast's case and there was insufficient coordination of these services, disrupting the necessary continuity of care and information required to provide safe care for Mr. Fast.

13. Develop guidelines to ensure that whenever possible patients and families are directly involved in meetings regarding the planning of their care.

14. Require the completion, at monthly intervals and at discharge, of comprehensive accurate summaries covering the medical, social, and psychiatric needs of patients in hospital and the required plans for treatment and care. These documents must have sufficient information to safely manage ongoing care by any provider and should be available electronicaly in a timely fashion. In addtion, these should be shared with the patient or their substitute decision maker. In cases where a patient has been identified as vulnerable or medically fragile these summaries must be available immediately for access when the patient leaves the institution.

    Coroners Comments:
    The inquest heard that staff participated in many hours of discussion and case conferences regarding Mr. Fast. There were no specific records documenting or summarising these deliberations and none of the meetings directly involved Mr Fast, even after he was deemed a voluntary patient, competent to make his own discharge decision.

15. In cases where a patient has been identified as having an unstable life threatening medical condition and they have discharged themselves against medical advice, every effort should be made by care staff to contact the patient, family, and other care providers and to follow up to ensure that care is available.

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16. Explore the development of low-barrier long-term care facilities for patients with complex medical and or psychiatric conditions whose needs cannot be met in the hospital or the community.

Coroners Comments:
Many of the care providers involved in helping Mr. Fast to find suitable ongoing care testified that there are no facilities set up to deal with the patients who do not fit into existing programs due to their complex medical, psychiatric and behavioural needs.