Ministry of Public Safety
and Solicitor General
Coroners Service
Province of British Columbia

File No. : 2015 : 0378 : 0078

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

SURNAME	GIVEN NAMES
CHARLES	Sarah Louise

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

in the Province of British Columbia, on the following dates September 7-16, 2016

before: Dontia Kuzma, Presiding Coroner.

into the death of CHARLES (Last Name) Sarah (First Name) Louise (Middle Name) 41 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: April 26, 2015 1020 Hours

Place of Death: 3190 Gladwin Road (Location) Abbotsford, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Blunt Force Trauma

Due to or as a consequence of

Antecedent Cause if any: b) Fall from a height of 10 storeys

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 16 day of September AD, 2016

Donita Kuzma
Presiding Coroner's Printed Name

Dkuzma
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Donita Kuzma
Inquest Counsel:	Mr. Bryant Mackey
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. A. Howden-Duke, counsel for Fraser Health Authority, Mr. D. Pilley, counsel for Dr. Zia-Ui Haque, Dr. Abid Khattak, Dr. Onome Agbahovbe, Ms. A. Srivastava, counsel for Abbotsford Police, and Ms. S. Stanton, counsel for Attorney General of Canada, RCMP.

The Sheriff took charge of the jury and recorded 14 exhibits. 41 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

A close family member of Sarah Charles testified to the many stressors and losses in her life, including being subjected to domestic violence and sexual assault. Ms. Charles had been living in the USA for several years and, after losing custody of her two children, she returned to British Columbia to live with her mother in 2011. Ms. Charles used alcohol and illicit drugs to cope with her traumatic experiences and she made multiple attempts to end her life. Each attempt would result in a short stay in in hospital and referrals to various treatment programs.

Ms. Charles had been diagnosed with alcoholism and would experience alcohol induced psychosis when she drank heavily. She was also diagnosed as having a mood disorder and borderline personality disorder.

On April 21, 2015, Ms. Charles was staying with her mother when she took an overdose of her prescribed medication. She was taken to the Abbotsford Regional Hospital where she was unconscious for two days. On April 24, a psychiatric assessment was performed. Ms. Charles wanted to leave the hospital and eventually left against medical advice on April 25. Her mother did not feel her residence was a safe place for her daughter as she lived in an apartment on the 10th floor, but Ms. Charles had nowhere else to go. After she arrived at her mother's residence, Ms. Charles obtained some alcohol and drank until she fell asleep. On the morning of April 26, while her mother was asleep, Ms. Charles jumped off the balcony of the apartment. Emergency health services and RCMP were called to the scene. Ms. Charles was pronounced deceased, having sustained obvious multiple blunt force injuries.

Ms. Charles's death was the second of three involving patients who died within 24 hours of leaving the Abbotsford Regional Hospital psychiatric ward. The other two deaths were those of Brian David Geisheimer : B.C. Coroners Service case number 2014 -0228-0249, and Sebastien Pavit Abdi: B.C.

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Coroners Service case number 2015-0378-0080. The deaths occurred between December 28, 2014 and April 26, 2015. All three deaths were examined as part of this inquest and all ruled suicide by the jury. The jury made one set of recommendations based on the circumstances of the deaths and the evidence and witness testimonies presented during the inquest.

The inquest focused on issues regarding family involvement in the care of their family member, family access to patient information , availability of supportive community resources, suicide risk assessment training and practices for health authority staff, and suicide prevention strategies. An expert witness from the Canadian Mental Health Society testified about the need for evidence based suicide intervention and prevention strategies.

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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: Fraser Health Authority

1. Consider amending the Code Yellow policy with the following conditions: remove the differentiation between pre-code and code procedures; reconceptualise the flow chart and instructions so that procedure is followed based on risk factors/Mental Health Act certification; include the immediate request of police to ping the patient's cell phone if the patient is considered to be high risk and in possession of their cell phone; equip psychiatric units with radios to improve the efficiency of communication between staff when searching for the patient; and permit staff and possibily contractor, the ability to follow patients, if the elopement is witnessed, at a safe distance as far is possible, and with radios, in order to improve the accuracy of communication regarding the patient's whereabouts and police ability to safely locate and return the patient to the hospital. Staff should wait for response from the police pinging cell phone and then call patient.

Presiding Coroner Comment: *The jury heard a Code Yellow is activated when a patient goes missing from or does not return to a hospital ward in the Abbotsford Regional Hospital. The jury heard evidence the flow chart showing Code Yellow actions was difficult to understand and that there were delays in the Code Yellow response on the day Mr. Geisheimer left the hospital. The Code Yellow ended once it was confirmed he left the hospital and his phone was not pinged.*

2. Consider mandating the annual review of colour-coded policies for all hospital care providers and support staff.

Presiding Coroner Comment: *The jury heard that hospital and security staff did not receive regular training in the Code Yellow response.*

3. Consider implementing the use of documentation tools that are specific to the screening, comprehensive assessment and safety planning regarding suicide risk.

Presiding Coroner Comment: *The jury heard an expert witness testify to the need for hospitals to consistently use documentation tools that are specific to the screening, comprehensive assessment and safety planning regarding suicide risk. Testimony and evidence presented revealed that hospital staff were inconsistent in their documentation of screening, comprehensive assessment and safety planning regarding suicide risk.*

4. Consider amending the Suicide Risk Management Clinical Practice Guideline by removing risk categorizations of low, medium and high and replace them with more fluid conceptualizations of suicide risk and the decision-making regarding care planning that follows.

Presiding Coroner Comment: *The jury heard testimony from an expert witness that the Suicide Risk Management Clinical Practice Guideline could be improved by removing risk categorizations of low, medium and high and replace them with more fluid conceptualizations of suicide risk and the decision-making regarding care planning.*

5. Consider implementing a policy akin to Vancouver Coastal Health Authority's Family Involvement Policy.

Presiding Coroner Comment: *The jury heard testimony that family members felt they could have been better informed of and involved with the care of their loved ones. The jury heard that the Vancouver Coastal Health Family Involvement with Mental Health and Addicitions Services Policy allowed for more information sharing with family, while still following the guidelines of B.C.'s privacy legislation.*

6. Consider setting up a separate admitting area in the emergency department for the intake of suicidal patients to maintain patient privacy.

Presiding Coroner Comment: *The jury heard testimony the emergency room at Abbotsford Regional Hospital was not set up in a way that allowed for patients to have private communication with health care professionals.*

7. The community care worker should review patient files when the patient is released from the hospital as it pertains to certification and decertification. Intention: to compare patient release conditions to intake conditions. This is to ensure that the patient is not being re-released into an environment that contains all of the same stressors that brought on acute care. If patient left the hospital against medical advice, the community care worker should be made aware of this.

Presiding Coroner Comment*: The jury heard testimony that the community care workers did not have access to patient's hospital files, and there was no process to advise community workers if the patient left hospital against medical advice.*

To: Fraser Health Authority
Garda Security

8. Consider developing a procedure that allows quick access to video footage of patients who are the subject of a code yellow, and protocols that allow the footage to be immediately shared with police agencies when a Mental Health Act Warrant is enacted.

Presiding Coroner Comment: *The jury heard that were barriers to accessing video footage in a timely manner when a code yellow is implemented.*

9. Consider reviewing the response protocols for security guards with a view to improve and coordinate responses to colour coded incidents. Conduct mock colour code incidents on a regular basis.

Presiding Coroner Comment: *The jury heard that hospital security guards could be better prepared in their responses to colour coded incidents.*

To: Fraser Health Authority
Health Minister of BC

10. Consider expanding the mandate of Critical Incident Stress Debriefing to support families and community care providers following a death by suicide.

Presiding Coroner Comment: *The jury heard testimony from family members that they did not receive the emotional support from the Health Authority they felt they needed after the death of their loved one.*

To: College of Physicians and Surgeons of British Columbia
The Royal College of Physicians and Surgeons of Canada
College of Family Physicians of Canada
College of Registered Nurses of BC
BC College of Social Workers

11. Consider enhancing the standards of documentation to require specific evidence (including chronology) of the care provider's assessment of suicide risk and development of a collaborative safety plan.

Presiding Coroner Comment: *The jury heard evidence from an expert witness that the clinical and legal best practices for documenting suicide risk assessments and safety plans require the care provider to present rationale for their assessment of risk, supported by the evidence observed and provided by collateral sources, as well as a detailed safety plan that is client-specific and outlines different options for coping and support based on the circumstances of their predicted crises.*

12. Consider mandating annual suicide risk assessment and management re-training for health care and behavioural health professionals in order to maintain registration.

Presiding Coroner Comment: *The jury heard testimony from many care providers that they have not had any suicide risk assessment and management re-training since they graduated from their respective programs.*

To: College of Physicians and Surgeons of British Columbia
The Royal College of Physicians and Surgeons of Canada
College of Family Physicians of Canada
College of Registered Nurses of BC
BC College of Social Workers
BC College of Pharmacists

13. Consider creating an education program designed to educate all health care staff on the practical application of all the privacy laws regarding the sharing of health care information and mandate annual training and retraining as part of maintaining professional registration

Presiding Coroner Comment: *The jury heard testimony that family members were often told that privacy laws prevented health care professionals from sharing any information about patients, There was no specific training provided to health care staff regarding application of privacy legislation.*

To: Ministry of Public Safety and Solicitor General
British Columbia Association of Chiefs of Police

14. Consider expanding the scope of Victim Services to provide access to trained trauma counsellors, and to include support for families involved in a BC Coroners Service inquest regarding their loved one's death.

Presiding Coroner Comment: *The jury heard that family members did not receive the support they felt they needed to fully participate in the inquest process.*

To: Chief Coroner of British Columbia

15. Consider creating policy that stipulates that toxicology examination be done for all deaths within 48 hours of discharge from a hospital psychiatric ward.

Presiding Coroner Comment: *The jury heard evidence that no toxicology testing was performed in all three cases.*

To: British Columbia Association of Chiefs of Police

16. Consider ensuring that all police agencies have equal and efficient access to "be on the lookout for" notices.

Presiding Coroner Comment: *The jury heard evidence that "be on the look out notices" could be issued to all police agencies in a more timely and coordinated manner.*

To: British Columbia Association of Chiefs of Police
Health Minister of BC

17. Consider implementing additional interdisciplinary crisis response teams, similar to Vancouver Island Health Authority's IMCRT program, so that more communities have access to emergent support, referral and hospital liaison services.

Presiding Coroner Comment: *The jury heard evidence from an expert witness that crisis response teams play an important role in providing mental health care in the community and facilitating a smoother transition to hospital when needed.*

To: Health Minister of BC

18. Consider revising the Guide to the Mental Health Act, 2005 Edition, in order to provide contemporary guidance to practitioners regarding the application of the Mental Health Act.

Presiding Coroner Comment: *The jury heard evidence that the Guide to the Mental Health Act is dated.*

19. Consider resourcing emergency departments and psychiatric programs with the addition of addictions counsellors, therapists, and additional social workers.

Presiding Coroner Comment: *The jury heard evidence that emergency departments have limited social resources and that patients would benefit from the additional care and expertise that mental health and addictions practitioners can provide.*

20. Consider developing and implementing a case management communication system so that all involved inpatient and community care providers have access to the same information regarding the client's background (*including family/emergency contacts*) and plans for care and can engage in more assertive, collaborative ways to meet the needs of their clients.

Presiding Coroner Comment: *The jury heard evidence that, while some programs were designed to be more collaborative and allow for the ease of information-sharing between care providers (like in the case of Mr. Abdi), there were gaps between other services in the health care system that increased the risk of mental health and addictions professionals receiviing limited, or misinformed information about the clients in their care (as was the case for Ms. Charles).*

To: Health Minister of BC
Ministry of Children and Family Development

21. Consider increasing funding to provide evidence-based therapy methods to clients in both inpatient and community settings with a focus on treating emotion dysregulation and suicidal behaviour.

Presiding Coroner Comment: *The jury heard evidence that there is limited access to evidence-based therapy methods.*

22. Consider increasing resources to community mental health teams to reduce general waitlists, and to be able to respond to urgent referrals within a brief period of time and make contact with the patient before discharge from hospital.

Presiding Coroner Comment: *The jury heard evidence that Mr. Geisheimer felt restless and lacking in support while in hospital. The jury also heard evidence from an expert witness that the risk of transitioning a patient from an inpatient to community setting can be mitigated by facilitating a more relationally-based transfer of care.*

23. Consider adopting trauma-informed care principles as established by the BC Provincial Mental Health and Substance Use Planning Council. Specifically, consider how the principles of trauma awareness; an emphasis on safety and trustworthiness; the opportunity for choice, collaboration and connection; and strengths-based skill building apply to assessing, diagnosing and treating mental health conditions, substance use, and suicide risk, as well as to the involvement of family members and community supports in the care planning process.

Presiding Coroner Comment: *The jury heard evidence that Ms. Charles endured multiple traumatic experiences that impacted her health and well-being and that these experiences were not adequately or consistently reflected within her assessments or care plans.*

To: Health Minister of BC
First Nations Health Authority

24. Consider increasing funding to create additional licensed recovery houses and local detoxification programs across the Province of British Columbia to support clients seeking recovery from problematic substance use.

Presiding Coroner Comment: *The jury heard evidence that Ms. Charles struggled to locate appropriate resources to support her recovery from problematic substance use.*

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To: Health Minister of BC
Health Minister of Canada

25. Consider mandating the implementation of systematic and evidence-based suicide safer care initiatives across health care settings and health authorities in order to address the following: developing and evaluating leadership, policies and practices as they relate to safer suicide care; regulating the training of multidisciplinary care providers; improving the identification and treatment of suicide risk; engaging clients throughout the health care system; strengthening the process of planning for transitions and maintaining continuity of care between care providers; and conducting audits relevant to improving the standard of care.

Presiding Coroner Comment: *The jury heard testimony from an expert witness that health care systems can improve on providing suicide safer care by implementing evidence-based, systems-wide approaches to quality improvement.*

To: Health Minister of Canada

26. Consider developing and implementing a national strategy for suicide prevention as advocated by the Canadian Association for Suicide Prevention and the Federal Framework for Suicide Prevention Act.

Presiding Coroner Comment: *The jury heard testimony from an expert witness that Canada is one of the few industrialized countries that does not have a national suicide prevention strategy.*