BRITISH COLUMBIA

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File 2014:0228:0249

GEISHEIMER	Brian David
SURNAME	GIVEN NAMES

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: Donita Kuzma, Presiding Coroner.

into the death of GEISHEIMER (Last Name) Brian (First Name) David (Middle Name) 30 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: December 28, 2014 2103 hours

Place of Death: On railway tracks, near intersection of Lougheed Hwy and Manson Street (Location) Mission, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multiple Blunt Force Injury

Due to or as a consequence of

Antecedent Cause if any: b) Train/pedestrian collision

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

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.: 2015:0378:0080

ABDI	Sebastien Pavit
SURNAME	GIVEN NAMES

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 – 16th, 2016

before: Donita Kuzma, Presiding Coroner.

into the death of ABDI (Last Name) Sebastien (First Name) Pavit (Middle Name) 19 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: April 26, 2015 Between 1530 - 1730 hours

Place of Death: 3044 Clearbrook Road (Location) Abbotsford B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Asphyxiation

Due to or as a consequence of

Antecedent Cause if any: b) Cervical Ligature hanging

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

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.: 2015:0378:0078

CHARLES	Sarah Louise
SURNAME	GIVEN NAMES

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: Donita 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

Presiding Coroner's Signature

BRITISH COLUMBIA

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

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
GEISHEIMER	Brian David
ABDI	Sebastien Pavit
CHARLES	Sarah Louise

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 possibly contractors, 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 police pinging cell phone and then call patient.

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

3. Consider implementing the use of documentation tools that are specific to the 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. Substance abuse patients require a comprehensive suicide risk assessment.

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

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
GEISHEIMER	Brian David
ABDI	Sebastien Pavit
CHARLES	Sarah Louise

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

7. The community care worker should review patient files when the patient is released from hospital as it pertains to certification or 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 a patient left the hospital against medical advice, the community care worker should be made aware of this.

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

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.

To: Fraser Health Authority
Minister of Health

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

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

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
GEISHEIMER	Brian David
ABDI	Sebastien Pavit
CHARLES	Sarah Louise

11. Consider creating standards of documentation including chronology and the training regarding same, of the care provider's assessment of suicide risk and development of a collaborative safety plan.

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

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.

To: Minister 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.

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.

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

16. 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.

To: Minister of Health

17. 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.

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

19. 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. Care providers are to make use of the patient file information release consent form.

To: Minister of Health
Minister, Children and Family Development

20. 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.

21. 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.

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
GEISHEIMER	Brian David
ABDI	Sebastien Pavit
CHARLES	Sarah Louise

22. 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.

To: Minister of Health
First Nations Health Authority

23. 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.

To: Minister of Health
Minster of Health, Canada

24. 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.

To: Minister of Health, Canada

25. 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.