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

File Number: 2019-1008-0181

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
SPENCER	**PAUL RICHARD NATHAN**

An Inquest was held at Victoria Law Courts, in the municipality of Victoria

in the Province of British Columbia, on the following dates: September 9 – 20, 2024

before: Kirsten Everett, Presiding Coroner.

into the death of Spencer (Last Name) Paul (First Name) Richard Nathan (Middle Name) 43 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: September 27, 2019 (Date) between 5:34 and 5:42 a.m. (time)

Place of Death: Royal Jubilee Hospital (Location) Victoria, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Combined effects of physical restraint, Hypertensive Cardiovascular Disease, Psychosis NOS, and administration of sedating medication (long-term use of Respiridone)

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: [X] Accidental [ ] Homicide [ ] Natural [ ] Suicide [ ] Undetermined

The above verdict certified by the Jury on the 20 day of September AD, 2024

Kirsten Everett
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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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: Island Health

1. Increase representation of mental health workers and members of the PEERS program in the Psychiatric Emergency Services unit (PES).

2. Following a critical incident resulting in an unexpected death, consider ways to:

   (a) improve the collection and preservation of evidence for the purpose of subsequent reviews and investigations; and

   (b) ensure all evidence used for the purpose of subsequent reviews and investigations is reviewed for consistency and reliability.

3. Review policies and training regarding health risks to patients in mental health distress after they have been involved in a physical altercation or physically restrained. Specifically consider the close and constant monitoring of such patients for 30 minutes following physical altercation or physical restraint.

4. Record CCTV video and audio from seclusion rooms in PES.

5. Capture and record audio from all security cameras in PES.

6. Interview all persons involved in a critical incident resulting in an unexpected death, in any investigation of that incident.

7. Consider steps to ensure individuals are not left unattended in a prone position following physical restraint.

To: Minister of Health

8. Consider how to facilitate investigation of a critical incident resulting in an unexpected death by a party independent of the health authority in which the incident occurs.

9. Consider reviewing s. 51 of the *Evidence Act* to ensure public accountability regarding investigations into critical incidents resulting in unexpected deaths in health care facilities.