



CORONER'S REPORT
INTO THE DEATH OF

WILLIAMS
SURNAME

JOHN
GIVEN NAMES

OF

NORTH VANCOUVER
MUNICIPALITY OF RESIDENCE

I, Scott Fleming, a Coroner in the Province of British Columbia, have investigated the death of the above named, which was reported to Mark Coleman on the 22nd day of December, 2009, and as a result of such investigation have determined the following facts and circumstances:

Gender: MALE FEMALE
Age: 52 YEARS
Death Premise: HOSPITAL
Place/Municipality of Death: NORTH VANCOUVER Date of Death: DECEMBER 22, 2009
Municipality of Illness/Injury: NORTH VANCOUVER Time of Death: 2055 HOURS

MEDICAL CAUSE OF DEATH

(1) *Immediate Cause of Death:* a) Myocardial Infarction

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

DUE TO OR AS A CONSEQUENCE OF

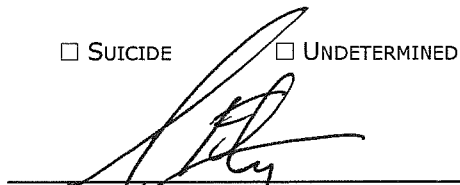
Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) *Other Significant Conditions Contributing to Death:*

BY WHAT MEANS Natural disease process

CLASSIFICATION OF DEATH ACCIDENTAL HOMICIDE NATURAL SUICIDE UNDETERMINED

Date Signed: DECEMBER 7, 2010



Scott Fleming, Coroner
Province of British Columbia



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INVESTIGATIVE FINDINGS

Mr. Williams was a 52 year old chronic paranoid schizophrenic who was well known to Community Psychiatric Services (CPS) in North Vancouver and Lions Gate Hospital (LGH) psychiatrists. Clinical records indicate that he had a long psychiatric medical history beginning at age 16, with three prior hospitalizations at Riverview Hospital and approximately seven at LGH. Mr. Williams was described as having a low psychiatric baseline, however over the years he was able to live independently. He was a reluctant participant in the services offered by CPS. He was recognized by both family and caregivers as a difficult client to engage and achieve optimal medical compliance due to the profound lack of insight which he had into his own condition as a result of his psychiatric illness. This lack of insight took on new significance with an acute deterioration in his physical health which took place in 2009.

On May 19, 2009 Mr. Williams was admitted for six days to LGH for acute respiratory decompensation secondary to pulmonary edema, right-sided heart failure and pulmonary hypertension. On May 23, 2009 Mr. Williams left the hospital voluntarily and against medical advice. Due to his acute medical condition and psychiatric history he was apprehended by RCMP and involuntarily admitted for 30 days under S. 22 of the *Mental Health Act* (MHA). The physicians who certified Mr. Williams identified his delusions which directly affected his ability to understand the nature of his illness and make logical decisions about his physical and mental health. A second physician noted that Mr. Williams was at significant risk of immediate medical complications, including respiratory decompensation and death, without supervised medical care and urgent psychiatric assessment to determine competence for self-care.

On May 25, 2009 Mr. Williams was given Leave Authorization pursuant to S. 37 of the MHA by the psychiatrist who had attended to him during his acute admission. According to the Form 20 completed as part of his approved leave, ongoing psychiatric care was to be assumed by a community psychiatrist. There were five conditions noted on the Form 20 Leave Authorization by the hospital physician: follow up with CPS; follow up a psychiatrist; take cardiac medications; take antibiotics; follow up for liver biopsy and cardiac investigations/treatment.

Upon discharge from LGH on May 25, 2009 a comprehensive Discharge Summary was prepared by the internist who had treated him in hospital. It noted that Mr. Williams was to follow up with the internist at his office to review his medical issues and with his community psychiatrist for his psychiatric issues. A copy of this Discharge Summary was provided to the community psychiatrist, CPS, and both treating internists. A copy was not provided to Mr. Williams' general practitioner.

Investigations determined that the community psychiatrist copied with the Discharge Summary had in fact stopped seeing Mr. Williams in early November 2006 and that psychiatric care had been transferred to another psychiatrist at CPS. Investigations conducted with the CPS psychiatrist and other members of the care team determined that they were aware of the conditions noted on the Leave Authorization and followed him in the community after discharge. Mr. Williams was well known to CPS who had followed him in the community for over 15 years. His psychiatric condition was described as being "low baseline", but stable, during the years that they had provided community care. Mr. Williams was described as a difficult patient to engage in his medical care. He disliked seeing physicians, and saw the role of CPS as more of a hindrance than a help. His lack of insight and medical compliance in treatment was assessed as being as a result



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of his underlying psychiatric illness. Mr. Williams was assessed as being competent, and no consideration had ever been given to appointing a substitute decision maker.

A CPS caseworker took Mr. Williams to one of his two follow-up appointments with his general practitioner. These visits were primarily concerned with his leg cellulitis, which appeared to be healing well. Blood pressure was taken on the two visits, with the last showing a satisfactory reading. The general practitioner had not been provided with a copy of the Discharge Summary detailing the full extent of Mr. Williams' medical condition, nor the conditions under which he had been granted Extended Leave during the term of his involuntary admission under S. 22 of the MHA.

Although it is not noted in the patient chart, the CPS psychiatrist advised during an interview that he assessed Mr. Williams before the expiration of his 30 day involuntary admission that was set to expire on June 25, 2009. In preparation for that assessment the CPS psychiatrist reportedly spoke to Mr. Williams' general practitioner to check on his acute medical condition. Based upon what he was told, and his uncharted assessment of Mr. Williams, the CPS psychiatrist found no basis to renew the Certificate for a further period of involuntary admission and Mr. Williams was discharged.

An interview with Mr. Williams' general practitioner determined that he saw Mr. Williams in hospital on one or two occasions, and then twice in his office in follow-up in June, 2009. The general practitioner had not seen the Discharge Summary until a copy of it was provided to him during the course of these investigations. He reported that the cellulitis condition was greatly improved with antibiotics. He confirmed that he took Mr. Williams' blood pressure and found that it had settled down nicely to within normal range. The general practitioner was not involved in any further medical follow up subsequent to his last visit on June 24, 2009.

Investigations conducted with the internist determined that Mr. Williams had an appointment to see him in his office after discharge but failed to attend. Although the internist could not advise as to what efforts, if any, were taken by his office to get Mr. Williams to attend, it is clear that neither the internist or general practitioner were involved in treating his medical condition subsequent to June 24, 2009.

A note on the CPS chart dated October 27, 2009 described a telephone call made by a CPS caseworker to "check up" on Mr. Williams. It was recorded that he was doing well, despite the recent death of his father. His legs had cleared up and he said that he was watching his weight and trying to eat a healthier diet and walking more often. He reported that he was seeing his general practitioner "on a regular basis".

Family members reported that Mr. Williams' physical health began to seriously deteriorate in the last half of 2009 as he developed obvious symptoms of serious cardiac disease including shortness of breath. In the weeks before his death Mr. Williams had difficulty getting out of bed and was not keeping up with his personal hygiene. It was reported that he was unable to walk more than 10 steps without stopping for breath. However, despite the urging of his immediate family, he adamantly refused to go to a hospital or see a physician. He disliked having people tell him what to do and maintained his independent views as to the cause of his condition. Family reported that Mr. Williams had unrealistic explanations for his obesity and shortness of breath.

Family members reported that Mr. Williams had a deep distrust of both physicians and hospitals and could not be convinced as to the logical need for medical care. Two days prior to his death he called a pharmacist to see if



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there were any medications he could take for his chest pain. The advice received from the pharmacist to see a physician was ignored by Mr. Williams.

A CPS chart note of November 16, 2009 recorded a telephone discussion which the CPS psychiatrist had with the general practitioner. It was reported that Mr. Williams had been seen in May or June of 2009 for a foot infection and that he was in pretty good shape. The chart note also records the concern of a close friend about Mr. Williams' condition, and the fact that he is in denial about his weight – estimated at 350 pounds. The chart note includes a reference to Mr. Williams being delusional about his weight and physical problem. An adjustment in his psychiatric medications was made.

A CPS psychiatrist and caseworker conducted an in-home assessment of Mr. Williams on December 10, 2009. During an interview with the CPS psychiatrist and caseworkers it was learned that the home assessment was made with a view to a possible committal, depending upon the results of their assessment. It was reported that in the months following his release from LGH, Mr. Williams' mental status was relatively stable, although his physical condition had deteriorated. The purpose of the home visit was to assess whether he had deteriorated mentally as a result of the progression of his chronic medical condition.

During the visit they found that the apartment was neat and tidy, Mr. Williams' demeanor was pleasant and cooperative, he was reportedly taking his medications, and that he would go to a physician if he wished to. He was not found to be in any acute medical or psychiatric distress. He further reported that he wished that his family was not continuously "bugging him" and that he could be left to deal with his own condition. On the basis of this assessment, the CPS psychiatrist concluded that there was no basis for an involuntary committal and that it would be inhumane to have Mr. Williams arrested by police against his will.

The CPS psychiatrist stated that he was well aware of the need to be concerned about Mr. Williams' deteriorating physical health in conjunction with managing his psychiatric care. The programs offered by CPS (and in which Mr. Williams appeared to have no interest in participating) were offered to achieve an integrated health and wellness approach to treatment. The CPS treatment plan was to continue to support Mr. Williams in his own home where he had functioned quite well for many years. There was never any consideration given to obtaining an Order for a substitute decision maker. Mr. Williams had a close girlfriend who provided him with emotional support, and it was the plan to continue to work with her and the family in attempting as best they could to achieve greater medical compliance from Mr. Williams. In the words of the CPS psychiatrist, "we were trying to follow a more trusting, autonomous view of treatment".

On December 22, 2009, Mr. Williams was found by a bystander collapsed on a roadway in North Vancouver. There were no vital signs present when he was first found. CPR was started by an off-duty firefighter and Mr. Williams was transported to LGH ER by ambulance. Despite further resuscitative measures, Mr. Williams was pronounced dead as a result of cardiac arrest.

As a result of my review of this death with the CPS psychiatrist and caseworkers, it became apparent that the issues illustrated by Mr. Williams' death are becoming increasingly common as a greater number of psychiatric patients, often with accompanying chronic and/or acute physical illness, are managed in the community.



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A smaller group of such a community patient population may, as a result of their underlying psychiatric illness, have limited insight into their physical and/or psychiatric health and therefore present difficult medical compliance and management issues for treating healthcare professionals. The circumstances under which physicians can or should make use of the involuntary committal procedures provided under the existing MHA, while seeking to balance optimal medical care with the patient's right to personal liberty and freedom to choose medical care, are brought into sharp focus when one reviews the medical and treatment history preceding the death of Mr. Williams.

As a result of my investigation of this death I am of the opinion that there is much which can be learned by members of the medical and healthcare communities as they seek to achieve this optimal balance within the context of available community healthcare funding and resources.

Accordingly, I am recommending a broadly based education and teaching initiative involving members of the Vancouver Coastal Health Authority, the College of Physicians and Surgeons of British Columbia and UBC Continuing Professional Development, as described in the Recommendations which follow.

POST MORTEM/TOXICOLOGY EXAMINATION

As a result of the circumstances surrounding the death of Mr. Williams, and the medical interventions which occurred immediately prior to death, there was no need to conduct additional postmortem investigations to determine a cause of death. Mr. Williams died as a result of an acute myocardial infarction.

CONCLUSION

I find that John Williams died in North Vancouver, B.C. on December 22, 2009 as a result of an acute myocardial infarction. I accordingly classify this death as natural.

Pursuant to Section 16 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agencies.

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Scott Fleming, Coroner
Province of British Columbia



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RECOMMENDATIONS

To: Vancouver Coastal Health Authority
11th Floor, 601 West Broadway
Vancouver, B.C.
V5Z 4C2

To: Community Psychiatric Services
1350 St. Andrews Street
North Vancouver, B.C.
V7L 3L4

1. That the Vancouver Coastal Health Authority and Community Psychiatric Services (CPS) coordinate a multi-disciplinary case review of the death of Mr. Williams, with the participation of all clinicians to include psychiatric nurses, community caseworkers, psychiatrists, internal medicine physicians and the Chiefs of these Departments, to consider and reflect upon how psychiatric patients, who also suffer from chronic or acute physical illness, can be more effectively managed in both the acute care and community care settings.
2. That the Vancouver Coastal Health Authority and Community Psychiatric Services (CPS) adopt a service delivery vehicle for those patients with sufficiently serious psychiatric illness, who also suffer from chronic or acute physical illness, which provides a more robust and intensive community care component, similar to the evidence based model of care known as Assertive Community Treatment (ACT).
3. That the Vancouver Coastal Health Authority distributes a copy of this Coroner's Report to all other community based multidisciplinary mental health teams such as CPS for their review.

To: Vancouver Coastal Health – Training Department
11th Floor, 601 West Broadway
Vancouver, B.C.
V5Z 4C2

4. That this Coroner's Report be used as a case study during training which is provided to admitting and medical records staff who have responsibility for determining the correct physicians to be provided with copies of Discharge Summaries, and other critical Consultation Reports. The need to ensure that this crucial step in providing continuity in patient care is understood and strictly followed by medical staff is clearly illustrated by the circumstances of this case.