A Reason to Hope. The Means to Cope.
British Columbia Schizophrenia Society
BC Schizophrenia Society Foundation
Supporting the BC Schizophrenia Society

January 31, 2014

Dr. Nigel Murray, President and CEO
Fraser Health Authority
Suite 400, Central City Tower
13450 – 102nd Avenue
Surrey, BC V3T 0H1

Dear Dr. Murray,

The BC Schizophrenia Society is currently in the process of reviewing recommendations relating to mental illness made by the BC Coroners Service. As an organization dedicated to supporting families coping with mental illness and its devastating effects, the BC Schizophrenia Society has a keen interest in recommendations that can improve responses to mental illness within the health and justice systems.

I am writing to inquire how the Fraser Health Authority has responded to the recommendations noted below:

Inquest held at Burnaby Coroners Court in Burnaby, BC November 13th to 15th, 2012 into the death of Colette Marie Salemink (File No. 2010:0364:0124)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2012/docs/verdict-salemink-2012-11-15.pdf

Recommendation:

If a caregiver provides support for a mentally ill person they should be supplied with a detailed list of information of the resources that have been made available to the mentally ill person. Such as community services, local housing, legal help and local support. The caregiver should also be supplied with their legal options (i.e. Peace Bond or Restraining Order) and any other resources that may help them support themselves as well as the mentally ill person in their charge.

Recommendation:

If a Caregiver wishes to alter the conditions of 'the extended leave' then the psychiatric team or psychiatrist needs to ensure that the Caregiver's wishes are adhered to within 24 -36 hours. For example if the Caregiver is no longer willing to allow the patient to reside at their residence it is the

duty of the team to immediately find alternative accommodations. An updated Form 20 needs to be completed and submitted to all necessary parties (i.e. CPIC, Prime and medical authorities) within 48 to 72 hours.

Inquest held at Coroners Court in Burnaby, BC November 8th to 10th and 12th, 2010 into the death of Jasdeep Sandhu (File No. 2008:276:941)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2010/docs/verdict-sandhu-2008-0276-0941.pdf

Recommendation:

We recommend that Fraser Health Authority, upon patient discharge, provide support to patients to return safely home by calling family, proving bus tickets and schedules, etc.

Coroner's Comment: The jury heard evidence as to the circumstances surrounding Mr. Sandhu's departure from the ER after discussions with the charge nurse. Testimony was also heard as to the somewhat variable practices followed by nursing staff in determining whether a patient can safely return home after discharge.

Inquest held at the Coroners Court in Burnaby, BC June 1st to 10th, 2009 into the death of Ross Alexander Allan (File No. 2008:0369:0149)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2009/docs/verdict-allan-10-june-2009.pdf

Recommendation:

That all members of the health care team are trained that all MHA patients are for the most part, unable to provide true and accurate information on themselves. Therefore, the team must obtain and chart relevant collateral information from the family and/or other sources.

Recommendation:

That the Mental Health Act be revised to allow at the Psychiatrist's discretion, family members access to information, diagnosis, and inclusion in the treatment plan.

Recommendation:

That a patient's family or contact person is notified as soon as possible when a patient is determined to be missing as per Code Yellow Stage One procedure.

Inquest held at the Supreme Court of British Columbia in Vernon, BC November 12th to 14th, 2008 into the death of Christopher Paul Klim (File No. 2007:0562:0069)
http://www.pssg.gov.bc.ca/coroners/schedule/archive/2008/docs/verdict-klim-file-07-562-0069.pdf

Recommendation:

That a Provincial policy be developed regarding the apprehension of patients and/or clients with mental illness history when requesting police assistance.

Coroner's Comments: The jury heard evidence from Mental Health witnesses that there is no standard protocol in place; once Police were notified in this circumstance of the warrant to apprehend, the matter was basically turned over to them pending apprehension.

Recommendation:

Mental Health Warrants forwarded to the local police for execution will include an information check list, including but not limited to the following.

i. Details and descriptors of the patient and/or client.
ii. Known residences or potential locations to be found.
iii. Description of mental illness history, behavior and potential response to authority.
iv. History leading to the issuance of the Mental Health Warrant.
v. Mental Health contact person information.
vi. Other comments.

Coroner's Comments: The jury heard evidence from both Mental Health and Police witnesses who acknowledged the value of detailed information sharing and communication in these types of circumstances.

Recommendation:

Upon forwarding a Mental Health Warrant to Police the Mental Health contact person shall notify patient's and/or client's contact family members.

Coroner's Comments: The jury was presented with evidence that demonstrated the need for and assistance that family can provide to Mental Health and Police agencies that will assist bringing that client/patient to medical care.

I appreciate your attention to this request and look forward to receiving a response by February 28, 2014.

Sincerely,

Dave Halikowski
BC Schizophrenia Society Chair