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January 31, 2014

Dr. David Ostrow, President and CEO
Vancouver Coastal Health
11th Floor, 601 West Broadway
Vancouver, BC V5Z 4C2

Dear Dr. Ostrow,

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 Vancouver Coastal Health has responded to the recommendations noted below:

Inquest held at the Coroners Court in Burnaby, BC April 2nd to 4th, 2012 into the death of Matthew John Wilcox (File No. 2010-0270-0002)

<http://www.pssg.gov.bc.ca/coroners/schedule/archive/2012/docs/verdict-wilcox-2012-04-04.pdf>

Recommendation:

That when an individual is arrested by police and is brought to hospital and admitted, that all efforts are made to accommodate family visitation as soon as possible.

Recommendation:

That family members be promptly informed when a person in custody is admitted to hospital.

Recommendation:

That family members be informed when an individual is released from custody while in hospital.

Inquest held at the Coroner's Court in Burnaby, BC December 13th to 17th, 2010 into the death of Paul Glenn Boyd (File No. 2007:270:0809)

<http://www.pssg.gov.bc.ca/coroners/schedule/archive/2010/docs/verdict-boyd-2007-0270-0809.pdf>

Recommendation:

We recommend the establishment of a joint databank between the mental health department and the Vancouver Police Department of people with mental health issues.

Coroner's Comments: The jury heard evidence that police officers often encounter individuals with known mental health issues and that this information may not be available to the officers at the first response level.

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,

A handwritten signature in black ink, appearing to read 'D. Halikowski', with a small dot at the end of the line.

Dave Halikowski
BC Schizophrenia Society Chair