Ministry of the Solicitor General

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November 7, 2023

Public Health Hamilton
71 Main Street West
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To whom it may concern

Re: Patient Safety Review Committee Report (PSRC 2022-10)

Date of death: November 26, 2020
PSRC File No.: 2022-10 (2020-18590)

Please find enclosed a copy of the report and recommendations prepared by the Patient Safety Review Committee (PSRC) concerning the above-mentioned case.

The purpose of the PSRC is to assist the Office of the Chief Coroner in the investigation, review and development of recommendations towards the prevention of future deaths relating to healthcare-related cases where systems-based errors appear to be a major factor and to assist coroners in improving the investigation of deaths within, or arising from, the healthcare system in which system-based errors appear to have occurred.

Upon reviewing this case and preparing recommendations towards the prevention of future deaths, the PSRC has indicated that your organization may be in a position to implement recommendations **1 to 4**. I would appreciate your response to these recommendations by **May 7, 2024.**

If you feel the recommendations have been assigned incorrectly, your suggestions as to where to direct it would be greatly appreciated.

Please be advised that your response will be considered a public document and may be released to interested parties upon request.

PSRC recommendations are not legally binding; however, we trust they will be given careful consideration for implementation and, if not implemented, that your organization provides an explanation.

Please direct your response to:

Executive Lead – Committee Management
Office of the Chief Coroner
occ.deathreviewcommittees@ontario.ca

Thank you for participating in this important process. Please contact us if you have any questions.

Yours truly,

Reuven Jhirad, MD MPH CCFP FCFP
Deputy Chief Coroner
Chair – Patient Safety Review Committee

RJ:rg

Enclosure

PATIENT SAFETY REVIEW COMMITTEE

This document is produced pursuant to section 15(4) of the Coroners Act, R.S.O. 1990, c. 37, on the basis that it is to be used for the sole purpose of a Coroner's investigation, and not for any litigation or other proceedings unrelated to the Coroner's investigation. Moreover, the opinions expressed herein do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusions of the Coroner's investigation may differ significantly from the opinions expressed herein.

Date of death: November 26, 2020
Age: 38
File number: 2020-18590 (PSRC 2022-10)

Reason for review:
Concerns were raised with respect to monitoring in the shelter.

Documents reviewed:
1. Police Report
2. Coroner Report
3. Autopsy Report
4. Review of the Toronto Shelter Standards
5. Review of the Shelter By-law
6. Interview with Manager at Public Health Department - conducted May 11, 2023.
7. Interview with person with lived experience with addiction and homelessness - conducted May 16, 2023.

History:

The patient, who resided in a woman's shelter, had a history of polysubstance use, post traumatic stress disorder, and borderline personality disorder. She had frequent emergency visits related to substance use. On November 26, 2020, she was discovered by staff lying on the floor in her room deceased. The coroner documented early signs of decomposition. There was drug paraphernalia seen by the body. According to the police report, the patient was last seen alive on November 24, 2020. On November 24, she was observed entering her room alone on a video at 3:38 AM and was last spoken to by staff at 4:54 AM that day. On November 25, there was a door knock by staff twice with no response noted as per staff. A note was reported to have been left under her door. She was not seen or spoken to by staff on that day. On November 26, 2020, at 1:16 PM, staff

entered her room to clean the bathroom and to conduct water inspections in the bathroom. The door was held open by staff while the technician worked in the bathroom. The patient was not seen at this time. Staff later re-entered her room at 3:09 PM the same day and discovered her body by the bed. She was deceased. According to staff, the patient had been feeling unwell for the past few weeks and was spending time resting in her room. The mother raised concerns after her death that her daughter had last used her cell phone on November 22, 2020, and had not been seen for several days. An autopsy was conducted which concluded the cause of death as Fentanyl, Heroin, Methamphetamine, and Amphetamine toxicity. The manner of her death was deemed an accident. The coroner recommended daily recorded checks that would include ensuring that the person was conscious and responsive.

Post-mortem examination
Cause of Death: Fentanyl, Heroin, Methamphetamine, and Amphetamine Toxicity
Manner: Accident

Discussion:
To address the complex issue of preventing fatalities related to mental health and addiction disorders in the shelter system requires reviewing their policies.

According to the Mental Health Commission of Canada (MHCC), structural stigma can increase risk of adverse outcomes for persons with lived experience of mental health and addiction issues.[1] This may occur unknowingly through possible biases that can impact laws, policies, and practices which ultimately can impact the treatment of people.[1] Concerns exist for some of the approaches toward care of individuals with substance use challenges and mental health issues. There is a concern that some approaches are too restrictive in attempts to achieve treatment compliance.

An insightful remark from a participant in a study examining stigma associated with drug use stated “let’s not lose sight of the fact that effective treatment is one of the best antidotes to stigma” in their reference to readily available consumption sites and opioid agonist treatment in shelters. According to the BC Centre on substance abuse, there is a double standard in what sorts of substances are deemed acceptable and which are not.

In a discussion with a manager at a local Public Health Department there were several important considerations reviewed:

i. There has been an observation that being alone in a room increases the risk of overdose not just during the COVID-19 pandemic but at other times as well.

ii. Several shelters have attempted to implement several measures to reduce the risk of an overdose. These include: low barrier access to naloxone, overdose

[1] Mental Health Commission of Canada, 'Structural Stigma' (Mental Health Commission of Canada, accessed 15 May 2023) <https://www.mentalhealthcommission.ca/English/focus-areas/stigma-and-discrimination/structural-stigma>.

and harm reduction training for shelter workers and people who use drugs, the implementation of Urgent Public Health Need Sites (UPHNS) which are supervised consumption services, monitoring of drug use for people who use drugs by other people who use drugs (called safe spotting or peer witnessing), promoting technologies like the National Overdose Response service where you call if you are going to use, and if they can't reach you after they will call 911, and anti stigma training.

iii. The use of safety checks was reviewed and although it was stated that there was no definitive study supporting these checks reported it was stated that they could be beneficial if done properly. This would require the appropriate staff protocols, client input and the use of modern technologies as available.

There was also discussion with an individual who had lived experience with substance used for further information to inform possible recommendations. This conversation resulted in the following points for consideration:

i. The use of room and bathroom checks was known to occur and thought to be helpful in death prevention.

ii. Peer supporters/counsellors were felt to be quite helpful with substance-use related challenges.

Summary

With respect to the patient, the mother raised concerns that she had last used her cell phone on November 22 which would imply death for several days without being accounted for. According to the police report and video surveillance, the patient was seen without any reports of distress on November 24. However, on November 25, there were two door knocks only with no response and no room entry. A note was left for the patient. She was discovered the following day after room maintenance. Although her well being was unaccounted for on the day before her death, it cannot be extrapolated from this that her death could have been prevented. An overdose can occur rapidly. Checking on her the day before may not have changed the outcome. The fact that she was alone at the time without a peer support network to regularly account for her wellbeing may have been a more significant contributing factor.

Recommendations:

To the Shelter System, Local Public Health Units/Substance Use Divisions

1. Daily room checks should be conducted in a way to ensure the well being of the client. A room check consent should be obtained between the shelter and client with clear client expectations in how the daily room checks should be conducted to ensure safety.

2. A buddy peer system, supported by and overseen by the shelter, could be considered for use in shelters.
3. Harm reduction measures should be expanded with any available technologies to ensure residents are responsive.
4. Application of the Duty of Care Principle for all shelters – designed for and by shelter staff and the clients that use them.