North Shore
Schizophrenia Society

April 15, 2010 REGISTERED MAIL

Dr. Diane Rothon, Chief Coroner
Coroners Service of British Columbia
Metrotower II Suite 800 - 4720 Kingsway
Burnaby, B.C. V5H 4N2

Dear Dr. Rothon:

This is a request for an inquest into the death of John Benjamin (Ben) Williams of 2808 Eastern Avenue, North Vancouver BC, date of birth August 23, 1957. Died December 22, 2009 in emergency at Lions Gate Hospital, North Vancouver.

SUMMARY REASON

Mr. Williams, who suffered from schizophrenia and had no real insight into the nature and consequences of his physical deterioration, was allowed to die from a treatable heart condition.

BRIEF DESCRIPTION OF THE BACKGROUND

Mr. Williams was diagnosed with a heart condition, exacerbated by extra weight caused largely by anti-psychotic medication, but because he was mentally ill (schizophrenia), he didn't realize or acknowledge the risk he faced, didn't take the medication for his heart problem, and refused all help. His heart condition became increasingly more serious and distressingly obvious to those close to him. According to his girlfriend, his psychosis was also becoming more troublesome. A team from Community Psychiatric Services, North Shore, went to see him, but declined to commit him despite his serious physical deterioration, presumably on the grounds that he wasn't floridly psychotic. Similarly, a nurse at Lions Gate Psychiatry Acute Care told the family there was nothing they could do unless he came to the hospital on his own, which he wouldn't do, also because of his mental illness. Police and ambulance personnel, responding to a 911 call by his girlfriend, also decided they couldn't take him to hospital without his agreement. Not too long after, he collapsed on the street and died in Lions Gate Hospital emergency.

LIST OF REASONS FOR THIS REQUEST

There are several key issues to be looked at:

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1. Mr. Williams was left to his own devices when the danger he was in was apparent, while he himself was unable to recognize the danger.

2. In claiming there was nothing they could do, CPS and Acute Care appear to have ignored the provision in the B.C. Mental Health Act that allowed for the committal of Mr. Williams in the circumstances, namely the applicable clause in Section 22, "to prevent the person's or patient's substantial mental or *physical deterioration*." (Italics added.)

Also apparently ignored was the scope of the second self-standing criterion for committal in the Act, "for the protection of the person," a criterion allowing for a wide latitude of action, see *McCorkell 1993*.

The prior requirement for committal, that the person have a mental disorder, was clearly met.

3. Little or no attention was given to thinking through the connection between mental illness and untreated physical illness; what medical responsibility flows from that; and how the Mental Health Act and the Health Care (Consent) and Care Facility (Admission) Act might work together in the circumstances. *This is a major matter of growing general importance for the mentally ill.* Vulnerability to cardiovascular and pulmonary problems and to type 2 diabetes, and the heightened risk from physical illness for the mentally ill, under the umbrella diagnostic category "metabolic syndrome," is now well-documented and of crucial clinical importance. How to deal with such vulnerability and risk in urgent situations, especially where the person, because of a mental disorder, has limited insight into their physical risk, is similarly of crucial clinical importance.

4. Some due diligence was omitted, most notably the CPS psychiatrist's failure to interview Mr. Williams' long-time girl-friend who saw him almost daily and knew of mental difficulties he was having that he hid from others.

5. As noted above, we believe the legal means were in place, and the medical responsibility was clear, for taking Mr. Williams under hospital care and preventing his imminent death from his heart condition. If not, however, then another question arises: What new legislative provisions are required to allow for the necessary treatment of such persons in these circumstances where mental illness, with its lack of insight, and physical illness are intertwined?

6. Also requiring examination is a second explanation offered for not hospitalizing Mr. Williams, specifically that there was no place in hospital for people like Mr. Williams. Presumably this is a reference to someone needing treatment for a physical illness where the mental illness and difficulties it presents also have to be taken into account.

7. Further to be examined: the role of emergency services (police and ambulance paramedics) in such circumstances. Two general questions need to be looked at: (a) How does "acting in a manner likely to endanger that person's own safety" – the police power

in Section 28 – apply to situations like this, and (b) when Section 28 cannot be used, but the need for hospitalization is apparent, what reporting mechanisms are in place by which the police communicate this need to community mental health services, whose ability to act, under Section 22, is much broader?

DETAILED CHRONOLOGY (inasmuch as we have been able to piece it together)

While acute heart failure was the immediate cause of Mr. Williams' death, the underlying cause was his mental illness, which prevented him from fully understanding the need for treatment.

Instead of committing him to hospital where he might have been helped, however, Lions Gate Hospital psychiatric acute care and Community Psychiatric Services (CPS) maintained they were unable to act, despite the pleading of his family and girlfriend.

"He's going to die," his mother agonized at the time.

Mr. Williams, in his early fifties, suffered from schizophrenia. He was affable and much liked by those who knew him. In late spring 2009, he was diagnosed with a heart condition and prescribed medication for it. He took it for a while and then stopped.

He developed classic symptoms of heart disease, like shortness of breath and swollen and puffy features, not helped by a huge belly (the result of olanzapine; he had since been switched to risperidone). A case worker noticed his fingertips were blue. In his last weeks he had difficulty getting out of bed and was not keeping up with his hygiene. He couldn't walk more than ten steps without stopping for breath; he had already abandoned the regular daily walks which he had done for years. He adamantly refused, however, to go to hospital; grew red in the face and angry if pressed about it. He claimed he had no need for it, and offered unrealistic explanations for his obesity and shortness of breath. He didn't like people telling him what to do and had a deep antipathy to hospitals. He also generally avoided doctors, regardless of complaints he might have and family members bringing to his attention the logic of seeing a doctor. (In keeping, two days before he died he called the pharmacy complaining of chest pains and asking if there was something he could take for it. The pharmacist suggested he see a doctor. He didn't want to do that.)

As well as ignoring his heart medication, he had cut his risperidone dose in half because he thought the medication affected his sleep, although he felt better with the regular dosage. After a single visit to a CPS health and wellness clinic to see about diets, he also had refused to go back to the clinic, claiming he could look after dieting himself, which however he was unable to do. At the same time he continued to suffer from what his girlfriend described as "terrible hallucinations," menacing and distressful and causing him considerable anguish, which he talked about to his girlfriend, but hid from others.

In summary, he was seriously mentally ill; wasn't able to manage his health properly; avoided group help (hospital, wellness clinic); didn't understand how sick he really was (among other signs, he kept telling his mother not to worry, things would work out), and had put himself in danger.

Finally, in response to repeated concerns of his mother and girlfriend and of a sympathetic case worker, a psychiatrist and nurse from CPS went out to see him. Mr. Williams presented well and his apartment was tidy. The psychiatrist decided he didn't qualify for certification – ignoring, to judge from the circumstances, the "substantial physical deterioration" criterion for committal in the Mental Health Act and also ignoring the protection clause.

In a subsequent telephone conversation, the nurse told the family to pull back – that Mr. Williams should be left alone.

Not long after, his two sisters, seeing the difficulty he was in, went to the psychiatric ward at Lions Gate Hospital. A nurse there said that because of Mr. Williams' refusal to go to hospital, their hands were tied.

At roughly the same time, his girl-friend, alarmed at some swelling she noticed, called 911. He had also been showing signs of developing incontinence, wetting his pants and occasionally soiling them, which his girlfriend had to clean up for him. He also hadn't dressed for two days. The police and an ambulance arrived, but claimed they didn't have the power to take him to hospital involuntarily and he wouldn't agree to come with them.

Three days later, on December 22, Mr. Williams left his apartment for a short walk to his bank. He collapsed on the street and died in emergency at the hospital.

Subsequently another explanation surfaced for his not being committed. The family was told, after his death, that the problem was there was no place in the hospital to put people like Mr. Williams.

Thank you for your consideration of this request.

Yours sincerely,

Herschel Hardin, President
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