



Office of  
the Chief  
Coroner

F 2001 File Q2001-44  
**VERDICT OF CORONER'S JURY 44**

Q2001-44

We

of  
of  
of  
of  
of

BURLINGTON, ONTARIO  
BURLINGTON, ONTARIO  
OAKVILLE, ONTARIO  
ACTON, ONTARIO

Surname: DURNFORD,

Given Names: JOSHUA DOUGLAS

aged: 18 held at: MILTON PROVINCIAL COURT, 490 STEELES AVE.,  
MILTON, ONTARIO

on the days of: APRIL 23,24,25,26,27,30,  
DAYS OF, MAY 1,2,3,4,7,11,14,15, Aug 31  
DAYS OF JUNE, 26, 28, DAYS OF AUGUST, 23,24, 2001.

by: DR. KEVIN FLYNN Coroner for Ontario ^

having been duly sworn, have inquired into and determined the following

1. Name of deceased: JOSHUA DOUGLAS DURNFORD
2. Date and time of death: FEBRUARY 15, 2000 AT 12.01pm
3. Place of death: MILTON DISTRICT HOSPITAL P.A.C.
4. Cause of death: NEUROLEPTIC MALIGNANT SYNDROME OCT 12 2001
5. By What means: ACCIDENT REGIONAL SUPERVISING CORONER

(Continue on page 2 if necessary)

This Verdict was received by me this thirty first day of August 19 2001

Kevin Flynn  
Signature of Coroner

Distribution Original - Regional Coroner for forwarding to Chief Coroner Copy - Crown Attorney

# VERDICT OF THE JURY IN THE INQUEST INTO THE DEATH OF JOSHUA DURNFORD

DATE OF DEATH: February 15, 2000

We wish to make the following recommendations:

## Ministry of the Community and Social Services

1. The Ministry of Community and Social Services develop a computerized tracking system to monitor movement of youth across all residential service sectors. A computerized tracking system will reduce the movement of young people in care, enhance safeguards, help to determine the effectiveness of existing programs, and reinforce accountability.
2. The Ministry of Community and Social Services establish a threshold indicator at which a child's movement will be reviewed. This indicator must begin tracking at the point of service activation.
3. The Ministry of Community and Social Services ensure that the first out of home intervention is decisive, and is of sufficient intensity to meet the identified needs of the child and family.
4. Treatment plans for out of home interventions should be derived from a comprehensive need and risk assessment that is holistic and accountable to the child's community.
5. The Ministry of Community and Social Services ensure that a single case manager should be assigned to follow each child from point of entry into the system to discharge, regardless of the program, service sector or Ministry involved. The single case manager is to be advised immediately of any significant incident/change in the child's life while in their care.
6. The Ministry of Community and Social Services require that comprehensive assessments be completed at the point of entry into the care system. These include neuro-developmental assessments where indicated by behaviour. Treatment plans and interventions are driven by these assessments.
7. The Ministry of Community and Social Services ensure that highly skilled assessment resources be made available for cognitively impaired children and youth with behavioural risk issues.

8. The Ministry of Community and Social Services establish a regulatory body as the licensing authority that specifies minimum levels of staff qualifications, education and training for those youth workers working in licensed agency facilities. This external quality assurance mechanism would stipulate the requirements for programming, behaviour management practices, supervision, staff training and development and accessibility to information. Emphasis should be placed on issues of consent and capacity, community accountability, case planning, crisis management, and the use of intrusive disciplinary measures.
9. The Ministry of Community and Social Services develop licensing standards that any staff who work with youth in residential settings be trained in youths' rights and freedoms around consent to medications and treatment, confidentiality of records, and in their obligations under the following Acts: *Health Care Consent Act, 1996; Mental Health Act; Substitute Decisions Act; and Child and Family Services Act.*
10. The Ministry of Community and Social Services establish specialized residential services dedicated to addressing the complex needs of developmentally handicapped sex offending youth.
11. The Ministry of Community and Social Services fund at full cost more residential treatment spaces for children in care of all ages so that severely disturbed children can receive the residential treatment they require. Such intervention services need to include a full range of psychiatric, clinical, behavioural and pharmacological consultation as needed. Actual or full cost funding should be extended to former Crown Wards who are receiving services from the Children's Aid Society by way of Extended Care and Maintenance Agreements.
12. There should be clearer Ministry of Community and Social Services and/or Children's Aid Society policies regarding the criteria for the provision of assistance to former Crown Wards on Extended Care and Maintenance Agreements, including a clear statement of the legal significance of that status, both for the former crown ward and the supporting Children's Aid Society.

#### **Ministry of Correctional Services**

13. The Ministry of Correctional Services provide comprehensive, mandatory and ongoing training on protocols for emergency medical situations.
14. The Ministry of Correctional Services provide sufficient medical staff to adequately care for the large and complex needs of the population in correctional facilities. This would include the hiring of Nurse Practitioners and additional nursing staff to accommodate 24 hours per day, 7 days a week. This is to fulfill complex needs within the facilities and would include access to the health care unit and medical records at all times.

- 15 The Ministry of Correctional Services appoint a mediator to work within the correctional facility involved in this inquest, to work with correctional services staff and health care unit staff in establishing team effort and a healthy working environment.
- 16 The Ministry of Correctional Services create true medical observation units within correctional and detention facilities in which health care staff can observe the progress of an unwell inmate.
- 17 The Ministry of Correctional Services develop a policy that nurses conducting medication rounds should not be solely responsible for assessing inmates and that the detention and correctional services be staffed with the appropriate number of nursing staff to ensure that assessments can be conducted in accordance with Ministry policy and professional standards.
- 18 The Ministry of Correctional Services develop a proactive monitoring mechanism for assessing the delivery of health services within the correctional system. Correctional Services should abandon the unwritten policy of relying on the health discipline colleges and inquests as a means of ensuring quality control within its facilities.
- 19 The Ministry of Correctional Services develop portable nursing assessments kits including instruments for assessing an individual's complete vital signs that will ensure both the safety of nursing staff and that proper assessments can be conducted.
- 20 The Ministry of Correctional Services develop a means for ensuring that the observations of correctional officers relating to the health of an inmate form part of the health record of the inmate without allowing access to an inmate's health record.
- 21 The Ministry of Correctional Services establish an annual post-orientation in-service training program for nurses, including a review of policies and procedures.
- 22 The Ministry of Correctional Services strictly enforce the reporting obligations of correctional officers and nursing staff following the death of an inmate. This should be done prior to the end of the employee's shift or within 24 hours.
- 23 The Ministry of Correctional Services require that health care staff receive comprehensive, mandatory and ongoing training in psychiatric illnesses and medications.
- 24 The Ministry of Correctional Services require that correctional staff document every time they contact the HCU or OM16 with serious concerns about an inmate's health and well-being.

- 25 The Ministry of Correctional Services require that health care staff receive comprehensive, mandatory and ongoing training around consent to medication and treatment, informed consent, the awareness of the rights of the mentally challenged persons, consent to transmit information and the following Acts: *Health Care Consent Act, 1996; Mental Health Act.*
- 26 The Ministry of Correctional Services take steps towards the accreditation of its Health Care Units by the appropriate agency.
- 27 The Ministry of Correctional Services devote annual funding and resources to the continuing education of all staff employed in correctional institutions, on the following topics:
- the special needs of inmates with mental health challenges;
  - the therapeutic, overdose and adverse effects of neuroleptic and psychotropic drugs;
  - the need for the identification and careful monitoring of inmates who have regularly received neuroleptic and psychotropic drugs prior to incarceration;
  - the availability of resources that can provide emergency assistance in diagnosing inmates experiencing medical difficulties, including the institution's physicians on call, consultation with local hospitals and the availability of the NMS Hotline, operated by the Neuroleptic Malignant Syndrome Information Service.
- 28 The Ministry of Correctional Services install a Fax machine in the Health Care Unit at each correctional facility and provide training for its use.
- 29 A recommendation that requests by health care providers, working in correctional institutions, for personal health information relating to medical treatment decisions indicate the need for immediate attention by priority ranking. To this end the recommendation could include a direction that the Ministry of Correctional Services to amend the standard Fax Cover Sheet used by Health Care Units in correctional facilities to include priority rankings, such as:
- Urgent – Telephone follow-up required immediately
  - Urgent – Respond within 24 hours by return fax
  - Non-urgent – Request for health/clinical records required by \_\_\_\_\_

### **Children's Aid Societies**

- 30 The Ontario Association of Children's Aid Societies develop a training program for staff on the law of consent and capacity, confidentiality of health information, treatment decision making, understanding assessments and plans of care.

- 31 The Ontario Association of Children's Aid Societies develop a manual for workers relating to the laws of consent, confidentiality of health information, treatment decision making, understanding assessments and plans of care.
- 32 Legal Guardians or those in *loco parentis* should attend bail hearings to ensure that alternatives to incarceration are considered and that the best interests of the child are attended to at the hearing.
- 33 That the Society develop guidelines for annual reviews of all children who are on continuing neuroleptic medication.
- 34 That the Society develop a consultative relationship with qualified medical professionals to provide advice to the Society, when necessary, with respect to issues affecting the administration of neuroleptic medication for children and youth in care.
- 35 That the Society develop a method of reorganizing files so that information pertaining to neuroleptic or psychotropic medication is easily identified in, and retrieved from child in care files.
- 36 That the Society creates a log or continuous health record of all neuroleptic or psychotropic medications for each child upon admission to care and completed by the worker as each child is given such medication. Such a record should contain information that identifies the drug by both its generic and brand names, the dosage, how it is to be administered or taken and the length of time the child has remained on the medication. The continuous health record should also contain a list of the most serious side-effects of each medication, either in isolation, or in combination with other medications that the child is known to be taking. Neuroleptic medication should be highlighted in such a summary for ease of review given the particular risk factors associated with the use of neuroleptic medication.
- 37 That the Society provide training to its staff and caregivers on the broad range of issues and legislation related to consent and substitute decision making on behalf of children and youth in care or on Extended Care and Maintenance Agreements.
- 38 That the Society develop specific policies and procedures to provide guidance to staff on the process for obtaining substitute decision-making authority when a medical professional determines that a child or youth lacks capacity to make decisions related to their care and treatment. Staff will need to understand how to properly exercise substitute decision making authority and how to assist youth to understand their rights and the legal process for challenging the health care practitioner's determinations.
- 39 That the Society consider the use of a Medic Alert Bracelet for a child/youth under their care who has limited cognitive skills and is on medications.

## Office of Child and Family Service Advocacy

- 40 It is recommended that the Child Advocate should ensure that all appropriate Ministries and child care service providers be made aware of, and understand, not only the rights of children as outlined in the *Child and Family Services Act*, but also the special needs and rights of the mentally challenged under wardship or on Extended Care and Maintenance Agreements.

## Ministry of Health and Long Term Care

- 41 A recommendation that the provincial Legislature amend section 35(1) of the *Mental Health Act, R.S.O. 1990, c. M.7*, to define "health facility" as including the Health Care Units of Correctional Institutions, as well as public hospitals, which would permit the emergency disclosure of an inmate's clinical record to health care providers in correctional institutions, under section 35(3)(e). For greater clarity, the proposed amendment to section 35(1) is set out, as well as the text of section 35(3)(e):

s. 35(1) In this section and in sections 36 and 36.3,

...

"health facility" means a public hospital governed by *the Public Hospitals Act, R.S.O. 1990, c. P.40* and a health care unit operated by a correctional institution, in which persons who are detained pursuant to the criminal justice system are receiving treatment;

s. 35(3) The... officer in charge may disclose or transmit the clinical record to or permit the examination of the clinical record by,

...

(e) a person currently involved in the direct health care of the patient in a health facility, without consent, if the delay required to obtain consent would result in the patient experiencing severe suffering, would prolong the suffering that patient is already experiencing or would put the patient at risk of sustaining serious bodily harm.

## College of Nurses of Ontario

- 42 A recommendation to the College of Nurses to hold the nursing staff at correctional facilities accountable and responsible for the same quality and standard of care that is available to all citizens of Ontario.

- 43 A recommendation to the College of Nurses of Ontario to continually caution nurses in regard to the increased risk of neuroleptic and psychotropic drugs especially concerning side effects and the increased risk of Neuroleptic Malignant Syndrome.

#### College of Physicians and Surgeons

- 44 A recommendation to the College of Physicians and Surgeons to hold physicians, psychiatrists, who prescribe neuroleptic and psychotropic drugs to an accountability/responsibility in understanding, and an awareness of the increased risk of the aforesaid drugs with regard to the following:
- The potential dangers and risks involved in prescribing multiple neuroleptic and psychotropic drugs to a patient at one given time. Special attention should be given to numbers of medications and dosages.
  - The use of these neuroleptic drugs for sedative purposes and the unnecessary risk associated with that measure.
  - The availability of the NMS Hotline, operated by the Neuroleptic Malignant Syndrome Information Service.
  - The increased risk of Neuroleptic Malignant Syndrome when using neuroleptic drugs.
- 45 A recommendation to the College of Physicians and Surgeons to provide continuing medical education and awareness to all physicians regarding the Law of Consent and Substitute Decision Making. Physicians should be reminded that it is their responsibility to receive informed consent by sharing benefits/risks/side effects/consequences of prescribed treatment. It is important to regularly remind physicians **“that the more intrusive the drug, the more important the understanding of consent”**.

Dr. Kevin Flynn, Coroner, 106 Lakeshore Road East, Suite 202, Mississauga, Ontario L5G 1E3

tel: (905) 278 6832 fax: (905) 274 3098

October 5, 2001

Dr. James Young  
Chief Coroner for Ontario  
26 Grenville Street  
Toronto, ON  
M7A 2G9

Re: Inquest into the death of Joshua DURNFORD, date of death February 15, 2000

Dear Dr. Young:

I enclose the verdict and recommendations of the jury in the above inquest, together with a summary of events leading up to the inquest.

The Inquest at Milton Courthouse commenced on April 23, 2001.

Assistant Crown Attorney: Mr. Andrew Goodman, Halton Crown Attorney's office.  
Court Reporter: Ms. Anne Crisci, Milton Courthouse.  
Coroner's Constables: Cst. Rob Garland, & Retired Constable William Riddel, HRPS  
Investigating Officer: Detective Alistair Watt, #1 District CIB, Halton Regional Police

Counsel for Parties with Standing:

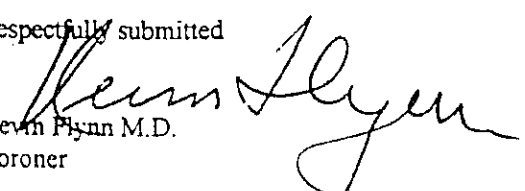
Ms. Lisa Ofiara for Ministry of Correctional Services  
Ms. Maureen Currie for Dr. Mech  
Mr. Dean Novak for Drs. Chan, Ben Aron, Johnson  
Mr. William Gilmour for Digs for Kids  
Mr. W. MacKenzie for Peel Regional Police Service  
Ms. A. Szigeti and Ms. S. Fraser for the Office of the Child Advocate  
Mr. D. Wiltshire for Children's Aid Society, Belleville  
Mr. E. Hoaken for the William Osler Health Centre and Linda Nasato  
Next of kin elected not to be present or be represented.

Total number of exhibits: submitted by coroner's constable.

Total number of witnesses: submitted by coroner's constable

Experts for the Coroner: Dr. Stuart McLeod, Professor of Clinical Pharmacology, McMaster University  
Dr. Patricia Rosebush, Associate Professor of Psychiatry and Behavioural  
Neurosciences, McMaster University, and a member of the Board of Directors of the Neuroleptic  
Malignant Syndrome Information Service.

Respectfully submitted

  
Kevin Flynn M.D.  
Coroner

Dr. Kevin Flynn, Coroner, 106 Lakeshore Road East, Suite 202, Mississauga, Ontario L5G 1E3

tel: (905) 278 6832 fax: (905) 274 3098

October 5, 2001

Dr. James Young  
Chief Coroner for Ontario  
26 Grenville Street  
Toronto, ON  
M7A 2G9

**P.A.C.**

OCT 12 2001

REGIONAL SUPERVISING  
CORONER

Dear Doctor Young:

Re: Inquest into the death of Joshua DURNFORD, age 18. Date of death February 15, 2000

CASE SUMMARY :

Joshua Durnford came under the care of the Children's Aid Society at the age of 10 as a result of extreme behavioral and interpersonal disturbances. As he progressed to adolescence first he exhibited bizarre sexual activity, verbal and physical aggression towards others as well as himself, delayed development, and profound under-socialization.

From 1992 he resided at 16 different residential and custodial facilities where management became increasingly difficult, eventually requiring one-to-one supervision. In 1997 he sexually assaulted a younger boy in a store washroom for which he served 180 days and in 1999 he was placed in a detention centre for assaulting a staff member at a group home. Subsequently, in July 1999 he was placed in a group home in Brampton on one-to-one supervision, which began at age 17 and continued under a Special Agreement with C.A.S. since he was 18 years of age.

In October 1999 he was diagnosed "homosexual paedophilia", and assessed for chemical castration at the Clarke Institute for control of his sexual predilections. Depo-Provera injection treatment was prescribed but had not commenced at the time of his death.

Following a single episode of suspected hallucinations in December 1999, he was admitted under Form 1 to the Psychiatry Unit at the local hospital, treated with Prozac which was discontinued at discharge. On discharge he was referred to a psychiatrist at the local Mental Health Clinic. His psychiatrist prescribed the following medications on December 1, 2000

Nozinan 25 mg/day

fluphenazine 25 mg i.m. every two weeks; (the prescription was written for 100 mg, but evidence at the inquest was that he was given 25 mg.) His last injection was given on January 27, 2000.

clomipramine 25 mg/day

Cogentin 2 mg/day.

He was also on Ritalin 20 mg /day

On December 2, the psychiatrist added alprazolam 0.5 mg every 6 hours as needed. On December 23, 1999 Nozinan was increased to 50 mg/day and clomipramine was increased to 50 mg/day. He attended his father's funeral on January 12, 2000 On January 14, 2000 Tegretol 200 mg/day was added. Concern was expressed by the supervisor at the group home to the psychiatrist regarding the number of psychotropic drugs. The last injection of fluphenazine was administered at the Mental Health Clinic on January 27, 1999. There was some differing evidence as to issue of consent and whether consent was truly obtained for this treatment.

On January 2, 2000 Joshua assaulted a staff member at the group home and was arrested, and charged with assault, threatening and breach of probation. On February 7, 2000 he again assaulted a staff member, was arrested and held in a cell overnight by Regional Police and taken to Court next day. He was refused bail and was sent to Maplehurst Detention Centre pending an appearance on February 15, 2000 and held in protective custody. On the evening of his transfer to M.D.C. a staff member at the group home telephoned the Health Unit there and provided a list of his prescribed medications. She was advised that medications would be provided through the Health Unit. He was assessed by the physician for the Detention Centre next morning and a mild resting tremor was noted. Later that day he was noted to have a pulse of 90, BP 144/102 and was described as shaking, tired, clammy and dysphoric. Consultation with the staff psychiatrist was requested. He was noted to be developmentally challenged, frightened and anxious. A Corrections Officer estimated his mental age to be about seven.

He was seen by the visiting psychiatrist for the Detention Centre on February 10. The psychiatrist expressed concern at the number and dosage of medications prescribed and he requested that information be obtained from the prescribing psychiatrist. Meanwhile all medications were discontinued except Nozinan, which was reduced to 25 mg/day. Noted by a C.O. that he felt he was talking to a child.

A signed consent and request for information was sent by fax to the group home physician from the Detention Centre on Friday, February 10, 2000.

On February 11, a C.O. mentioned that Durnford belonged in a hospital, not a jail.

On February 12, he was noted to be "shaky and diaphoretic", complaining of headache and having difficulty speaking. BP was 140/96. He was described as "afraid" and was admitted to the medical observation area in segregation. He spoke to a friend on the telephone and was noted to be afraid, and expressed the fear that he was not getting his medication.

On February 13, he had difficulty dressing himself and his hands were observed to be shaking uncontrollably. He was sent back to his cell. That evening he was noted to be sweating ("very diaphoretic") which was reduced after receiving his Nozinan 25 mg. Later he was observed to be "almost catatonic". A nurse who saw him on evening medication rounds noted that she thought he was in withdrawal from medication which had been discontinued.

On February 14 at 04:55 he was found lying face down on his mattress, shaking uncontrollably and complaining of feeling unwell. He was noted to be "weak and sweaty", his motor skills seemed to be poor and his muscle tone was "very rigid". He was returned to medical segregation, and was suspected of "withdrawing from narcotics". A correctional Officer asked the duty nurse if he should be sent to hospital and was advised there was "no immediate concern". At 10:45 on February 14 his speech was described as "slurred". He was rigid and his gait was unsteady. He was seen by the attending physician who felt that his symptoms were due to Parkinsonism secondary to medication or withdrawal. A faxed request for information was sent to the Mental Health Clinic at 12:15 and a follow-up telephone call was made. He was seen by a nurse about an hour later, flushed, shaking, stiff and unable to swallow Tylenol. The nurse wondered about a fever but did not take his temperature. At no time during his stay at Maplehurst was a temperature taken.

Later that day he was unable to dress himself and he had to be assisted to his feet by three officers, and was described as unsteady, unresponsive and drooling. He was also noted to be quite rigid. A nurse saw him at 13:30 and thought he had "a bit of fever", noted he was stiff as he came to the cell door to receive a Tylenol which he had difficulty swallowing. Again it was suspected that he might be withdrawing from medications. He was assisted to the shower and returned to his cell in segregation where he was given an extra mattress to sleep on the floor.

On February 15 he was sweating profusely, shaking and repeatedly asking for help. He requested fluids but was unable to hold a cup. He was unable to stand and his mattress was soiled by urine. Based on concerns voiced by Corrections staff and the fact that he became unresponsive and was "moaning" between 06:00 and 07:00, a nurse doing medications rounds was asked to see him. She looked through the door hatch but did not enter the cell or do any physical assessment.

At 09:00 the attending physician arrived. Pulse was "very high" and BP was moderately high. He was rigid and transfer to Milton Hospital was ordered. The nurse requested an ambulance on a "non-emergency" basis. The ambulance arrived at the Detention Centre at 10:08. He arrived at the Emergency Department at 10:45 and was pronounced dead at 12:02 on February 15, 2000.

At 14:50 the same day, as requested, the psychiatrist at the Mental Health Clinic sent by fax a report to the Maplehurst Psychiatrist with a list of medications:

Methotrimeprazine 25 mg hs  
Benztropine 2 mg hs  
Clomipramine 50 mg hs  
Fluphenazine 100 mg every two weeks  
Carbamazepine 200 mg hs.

Even at this stage, there was some confusion about the dosages of medication being prescribed. Post-mortem examination and two expert opinions attributed cause of death to be Neuroleptic Malignant Syndrome.

Issues in evidence included the following:

1. Informed consent;
2. Substitute decision making;
3. Indications for the number and doses of psychotropics/neuroleptics prescribed;
4. Communication between C.A.S., Group Home and the Mental Health Clinic regarding consent, number of medications;
5. Assessment of the individual in the immediate period before and following incarceration;
6. Lack of transmission of information on previous history and current medications from point of arrest through the custody process, appearance before Court, and remand to the Detention Centre;
7. Appropriateness of placement in an Adult Detention Centre for an adult, homosexual paedophile, with "the mind of a 12 year old";
8. Quality of nursing and medical attention provided at Maplehurst Detention Centre.
9. Delay at Maplehurst in obtaining relevant medical information.
10. Polypharmacy. There were concerns voiced by experts about the medication regime, and the apparent cross purposes of the medication prescribed especially since there was no significant history of psychosis.

Dr. Patricia Rosebush, Associate Professor of Neuropsychiatry at McMaster University, who has treated the largest number of cases of N.M.S. world wide, indicated in her expert evidence that if recognized early, N.M.S. treatment is successful, but if unrecognized and untreated, mortality rates can be 20% to 40%. The clinical features are: sudden onset of high fever, elevation of pulse and blood pressure, profound sweating and muscle rigidity and the syndrome develops over 48 to 72 hours. The risk factors are neuroleptics, especially injectable, polypharmacy, agitation and states of extreme fear, dehydration and there may be a dose relationship. Patients with compromised brain function may be more at risk. Treatment includes withdrawal of medications, aggressive supportive therapy with intravenous fluids, anti-pyretic agents, benzodiazepines for muscle rigidity. The most important preventive factors are increased awareness by physicians, patients and surrogate decision makers, to the early signs of toxicity in order that they can stop the medication, and appropriate use of neuroleptic medications.

## Durnford Recommendations

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36. That the Society create a log or continuous health record of all neuroleptic or psychotropic medications for each child upon admission to care and completed by the worker as each child is given such medication. Such a record should contain information that identifies the drug by both its generic and brand names, the dosage, how it is to be administered or taken and the length of time the child has remained on the medication. The continuous health record should also contain a list of the most serious side-effects of each medication, either in isolation, or in combination with other medications that the child is known to be taking. Neuroleptic medication should be highlighted in such a summary for ease of review given the particular risk factors associated with the use of neuroleptic medication.

37. That the Society provide training to its staff and caregivers on the broad range of issues and legislation related to consent and substitute decision making on behalf of children and youth in care or on Extended Care and Maintenance Agreements.

38. That the Society develop specific policies and procedures to provide guidance to staff on the process for obtaining substitute decision-making authority when a medical professional determines that a child or youth lacks capacity to make decisions related to their care and treatment. Staff will need to understand how to properly exercise substitute decision making authority and how to assist youth to understand their rights and the legal process for challenging the health care practitioner's determinations.

39. That the Society consider the use of a Medic Alert Bracelet for a child/youth under their care who has limited cognitive skills and is on medications.

The issue of informed consent and substitute decision making for persons in care of C.A.S. (including clients under Extended Care Agreements) was the subject of much evidence. It was unclear as to who was responsible for giving informed consent to the administration of the many psychotropic and neuroleptic medications to Joshua Durnford. The C.A.S. case worker signed "consent forms" without consulting with the prescribing psychiatrist and there was some confusion as to the strength and dose of fluphenazine injection prescribed.

## Office of Child and Family Service Advocacy

40. It is recommended that the Child Advocate should ensure that all appropriate Ministries and child care service providers be made aware of, and understand, not only the rights of children as outlined in the Child and Family Services Act, but also the special needs and rights of the mentally challenged under wardship or on Extended Care and Maintenance Agreements.

I agree.

## Ministry of Health and Long Term Care

41. A recommendation that the provincial Legislature amend section 35(1) of the Mental Health Act, R.S.O. 1990, c. M.7, to define "health facility" as including the Health Care Units of Correctional Institutions, as well as public hospitals, which would permit the emergency disclosure of an inmate's clinical record to health care providers in correctional institutions, under section 35(3)(e). For greater clarity, the proposed amendment to section 35(1) is set out, as well as the text of section 35(3)(e):

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## Durnford Recommendations

*(e) a person currently involved in the direct health care of the patient in a health facility, without consent, if the delay required to obtain consent would result in the patient experiencing severe suffering, would prolong the suffering that patient is already experiencing or would put the patient at risk of sustaining serious bodily harm.*

This recommendation arose from evidence that the detention centre health care staff were unable to access health records or information relating to Joshua Durnford without his written consent, (even though there was general agreement that his mental age was ten or twelve years), which when obtained was sent by fax to the office of the prescribing psychiatrist, was not initially marked URGENT and when finally received, he was already deceased.

### College of Nurses of Ontario

*43. A recommendation to the College of Nurses to hold the nursing staff at correctional facilities accountable and responsible for the same quality and standard of care that is available to all citizens of Ontario.*

*44. A recommendation to the College of Nurses of Ontario to continually caution nurses in regard to the increased risk of neuroleptic and psychotropic drugs especially concerning side effects and the increased risk of Neuroleptic Malignant Syndrome.*

I agree. It was indicated in evidence by the Senior Medical Consultant for the Ministry of Correctional Services that Maplehurst is now a "super jail", which includes 24 hour nursing services and creation of a Nurse Practitioner position. According to his evidence there is increased awareness of issues of consent and release of information.

### College of Physicians and Surgeons

*44. A recommendation to the College of Physicians and Surgeons to hold physicians, psychiatrists, who prescribe neuroleptic and psychotropic drugs to an accountability/responsibility in understanding, and an awareness of the increased risk of the aforesaid drugs with regard to the following:*

- The potential dangers and risks involved in prescribing multiple neuroleptic and psychotropic drugs to a patient at one given time. Special attention should be given to numbers of medications and dosages.*
- The use of these neuroleptic drugs for sedative purposes and the unnecessary risk associated with that measure.*
- The availability of the NMS Hotline, operated by the Neuroleptic Malignant Syndrome Information Service. (NMSIS)*
- The increased risk of Neuroleptic Malignant Syndrome when using neuroleptic drugs.*

*45. A recommendation to the College of Physicians and Surgeons to provide continuing medical education and awareness to all physicians regarding the Law of Consent and Substitute Decision Making. Physicians should be reminded that it is their responsibility to receive informed consent by sharing benefits/risks/side effects/consequences of prescribed treatment. It is important to regularly remind physicians "that the more intrusive the drug, the more important the understanding of consent".*

There was no clear evidence of psychosis other than one episode of suspected hallucinations, and the experts questioned the use and dosage and mix of the number of medications used.

The risk of N.M.S. would not generally be known to primary care physicians but psychiatrists should be aware of the risk and diagnostic markers, and the risk of N.M.S. should be pointed out to patients, substitute decision makers and primary care givers by the prescribing physician/psychiatrist.

See attached copy of a brochure published by NMSIS.

DATE OF DEATH: February 15, 2000

We wish to make the following recommendations:

Ministry of the Community and Social Services

1. The Ministry of Community and Social Services develop a computerized tracking system to monitor movement of youth across all residential service sectors. A computerized tracking system will reduce the movement of young people in care, enhance safeguards, help to determine the effectiveness of existing programs, and reinforce accountability.
2. The Ministry of Community and Social Services establish a threshold indicator at which a child's movement will be reviewed. This indicator must begin tracking at the point of service activation.
3. The Ministry of Community and Social Services ensure that the first out of home intervention is decisive, and is of sufficient intensity to meet the identified needs of the child and family.
4. Treatment plans for out of home interventions should be derived from a comprehensive need and risk assessment that is holistic and accountable to the child's community.
5. The Ministry of Community and Social Services ensure that a single case manager should be assigned to follow each child from point of entry into the system to discharge, regardless of the program, service sector or Ministry involved. The single case manager is to be advised immediately of any significant incident/change in the child's life while in their care.
6. The Ministry of Community and Social Services require that comprehensive assessments be completed at the point of entry into the care system. These include neuro-developmental assessments where indicated by behaviour. Treatment plans and interventions are driven by these assessments.
7. The Ministry of Community and Social Services ensure that highly skilled assessment resources be made available for cognitively impaired children and youth with behavioral risk issues.
8. The Ministry of Community and Social Services establish a regulatory body as the licensing authority that specifies minimum levels of staff qualifications, education and training for those youth workers working in licensed agency facilities. This external quality assurance mechanism would stipulate the requirements for programming, behaviour management practices, supervision, staff training and development and accessibility to information. Emphasis should be placed on issues of consent and capacity, community accountability, case planning, crisis management, and the use of intrusive disciplinary measures.
9. The Ministry of Community and Social Services develop licensing standards that any staff who work with youth in residential settings be trained in youths' rights and freedoms around consent to medications and treatment, confidentiality of records, and in their obligations under the following Acts: Health Care Consent Act, 1996; Mental Health Act; Substitute Decisions Act; and Child and Family Services Act.
10. The Ministry of Community and Social Services establish specialized residential services dedicated to addressing the complex needs of developmentally handicapped sex offending youth.
11. The Ministry of Community and Social Services fund at full cost more residential treatment spaces for children in care, of all ages, so that severely disturbed children can receive the residential treatment they require. Such intervention services need to include a full range of psychiatric, clinical, behavioral and pharmacological consultation as needed. Actual or full cost funding should be extended to former Crown Wards who are receiving services from the Children's Aid Society by way of Extended Care and Maintenance Agreements.
12. There should be clearer Ministry of Community and Social Services and/or Children's Aid Society policies regarding the criteria for the provision of assistance to former Crown Wards on Extended Care and Maintenance Agreements, including a clear statement of the legal significance of that status, both for the former crown ward and the supporting Children's Aid Society.

Evidence was given that Joshua Durnford was taken in care by the Children's Aid Society in Belleville at the parents request in 1992, because they were unable to control his anti social behaviour. He was fortunate to have the same case worker over most of his wardship but was admitted to a total of 16 institutions up to the time of his death. Placement became increasingly difficult, requiring one-to-one supervision and in the more recent placement request was made and granted for two-to-one supervision. Training of residential care workers in management of severely disturbed children or persons in care of C.A.S., with appropriate funding was felt to be essential in such homes. Training in the area of informed consent and substitute decision making appeared to be lacking. Limitation of moves and more consistency in the management environment was urged by professional witnesses.

### Ministry of Correctional Services

13. *The Ministry of Correctional Services provide comprehensive, mandatory and ongoing training on protocols for emergency medical situations.*
14. *The Ministry of Correctional Services provide sufficient medical staff to adequately care for the large and complex needs of the population in correctional facilities. This would include the hiring of Nurse Practitioners and additional nursing staff to accommodate 24 hours per day, 7 days a week. This is to fulfill complex needs within the facilities and would include access to the health care unit and medical records at all times.*
15. *The Ministry of Correctional Services appoint a mediator to work within the correctional facility involved in this inquest, to work with correctional services staff and health care unit staff in establishing team effort and a healthy working environment.*
16. *The Ministry of Correctional Services create true medical observation units within correctional and detention facilities in which health care staff can observe the progress of an unwell inmate.*
17. *The Ministry of Correctional Services develop a policy that nurses conducting medication rounds should not be solely responsible for assessing inmates and that the detention and correctional services be staffed with the appropriate number of nursing staff to ensure that assessments can be conducted in accordance with Ministry policy and professional standards.*
18. *The Ministry of Correctional Services develop a proactive monitoring mechanism for assessing the delivery of health services within the correctional system. Correctional Services should abandon the unwritten policy of relying on the health discipline colleges and inquests as a means of ensuring quality control within its facilities.*
19. *The Ministry of Correctional Services develop portable nursing assessments kits including instruments for assessing an individual's complete vital signs that will ensure both the safety of nursing staff and that proper assessments can be conducted.*
20. *The Ministry of Correctional Services develop a means for ensuring that the observations of correctional officers relating to the health of an inmate form part of the health record of the inmate without allowing access to an inmate's health record.*
21. *The Ministry of Correctional Services establish an annual post-orientation in-service training program for nurses, including a review of policies and procedures.*
22. *The Ministry of Correctional Services strictly enforce the reporting obligations of correctional officers and nursing staff following the death of an inmate. This should be done prior to the end of the employee's shift or within 24 hours.*
23. *The Ministry of Correctional Services require that health care staff receive comprehensive, mandatory and ongoing training in psychiatric illnesses and medications.*
24. *The Ministry of Correctional Services require that correctional staff document every time they contact the HCU or OM16 with serious concerns about an inmate's health and well-being.*
25. *The Ministry of Correctional Services require that health care staff receive comprehensive, mandatory and ongoing training around consent to medication and treatment, informed consent, the awareness of the rights of the mentally challenged persons, consent to transmit information and the following Acts: Health Care Consent Act, 1996; Mental Health Act.*
26. *The Ministry of Correctional Services take steps towards the accreditation of its Health Care Units by the appropriate agency.*

27. The Ministry of Correctional Services devote annual funding and resources to the continuing education of all staff employed in correctional institutions, on the following topics:

- the special needs of inmates with mental health challenges;
- the therapeutic, overdose and adverse effects of neuroleptic and psychotropic drugs;
- the need for the identification and careful monitoring of inmates who have regularly received neuroleptic and psychotropic drugs prior to incarceration;
- the availability of resources that can provide emergency assistance in diagnosing inmates experiencing medical difficulties, including the institution's physicians on call, consultation with local hospitals and the availability of the NMS Hotline, operated by the Neuroleptic Malignant Syndrome Information Service.

28. The Ministry of Correctional Services install a Fax machine in the Health Care Unit at each correctional facility and provide training for its use.

29. A recommendation that requests by health care providers, working in correctional institutions, for personal health information relating to medical treatment decisions indicate the need for immediate attention by priority ranking. To this end the recommendation could include a direction that the Ministry of Correctional Services to amend the standard Fax Cover Sheet used by Health Care Units in correctional facilities to include priority rankings, such as:

*Urgent – Telephone follow-up required immediately*

*Urgent – Respond within 24 hours by return fax*

*Non-urgent – Request for health/clinical records required by \_\_\_\_\_*

Health Care at the Detention Centre at the time in question was provided by a number of registered nurses, some full time, some part time, a physician who attended each morning, and a psychiatrist who attended once weekly. Staff shortages were common and some nurses worked double shifts. There was no in-service training for nursing staff on problems peculiar to the prison population, such as mental health and developmental problems, and there was no managerial system for nursing staff. Evidence at the inquest indicated a need for closer cooperation between Corrections Officers (C.O.s) and Nursing staff. There was no dedicated medical observation unit in the health care area. It was apparent from evidence that concerns over the inmate's condition expressed by C.O.s were repeatedly dismissed by nursing staff from February 13 onwards, as likely due to drug withdrawal, without appropriate assessment or reference to product monographs. Early on the morning of his death when he was described by the C.O. as "unresponsive" and his condition had "deteriorated" the nurse did not perform a nursing assessment.

### Children's Aid Societies

30. The Ontario Association of Children's Aid Societies develop a training program for staff on the law of consent and capacity, confidentiality of health information, treatment decision making, understanding assessments and plans of care.

31. The Ontario Association of Children's Aid Societies develop a manual for workers relating to the laws of consent, confidentiality of health information, treatment decision making, understanding assessments and plans of care.

32. Legal Guardians or those in loco parentis should attend bail hearings to ensure that alternatives to incarceration are considered and that the best interests of the child are attended to at the hearing.

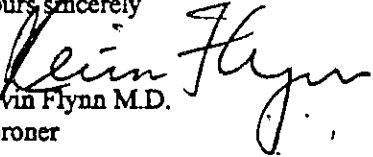
33. That the Society develop guidelines for annual reviews of all children who are on continuing neuroleptic medication.

34. That the Society develop a consultative relationship with qualified medical professionals to provide advice to the Society, when necessary, with respect to issues affecting the administration of neuroleptic medication for children and youth in care.

35. That the Society develop a method of reorganizing files so that information pertaining to neuroleptic or psychotropic medication is easily identified in, and retrieved from child in care files.

I attach some comments on the recommendations by the jury. These comments and the above summary are intended solely for guidance of interested parties and are based only on my personal recollection of evidence. If any party feels that my recollection is incorrect I would appreciate it if any gross errors could be brought to my attention and I will be pleased to make whatever correction is appropriate.

Yours sincerely

  
Kevin Flynn M.D.  
Coroner