- new -2001 file -Q2001-05

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

Office of the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury/ Verdict du jury du coroner

We / Nous soussignés, \

	of / de	Region of Waterloo
	of / de	Region of Waterloo
	of / de	Region of Waterloo
	of / de	Region of Waterloo
	of / de	Region of Waterloo

the jury serving on the Inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décés de:

Surname / Nom de famile	Given names / Prénom
LUFT	BILL

Aged / âgé(e) de 42 Years

held at / qui a été menée à 150 Frederick Street, City of Kitchener

on the / le 8th to 26th

day(s) of / (du/au) January 2001

by / par Dr. Karen Acheson, Coroner for Ontario / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) BILL LUFT

2. Date and time of death / Date et heure du décés JULY 6, 2000 at 12:10 p.m.

3. Place of Death / Lieu de décés 146 Mooregate Cr., Kitchener, Ontario

4. Cause of death / Cause du décés Gunshot wounds of head and chest

5. By what means / Circonstances entourant le décés Suicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____, _____.
Ce verdict a été reçu par moi le

Original signed by Coroner

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

Office of the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury/ Verdict du jury du coroner

We / Nous soussignés, of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

the jury serving on the Inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famile	Given names / Prénom
LUFT	BOHUMILA

Aged / âgé(e) de 27 Years

held at / qui a été menée à 150 Frederick Street, City of Kitchener

on the / le 8th to 26th

day(s) of / (du/au) January, 2001

by / par Dr. Karen Acheson, Coroner for Ontario / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) BOHUMILA LUFT

2. Date and time of death / Date et heure du décès JULY 6, 2000 at 11:33 a.m.

3. Place of Death / Lieu de décès 146 Mooregate Cr., Kitchener, Ontario

4. Cause of death / Cause du décès Haemorrhage and shock due to stab wound of abdomen

5. By what means / Circonstances entourant le décès Homicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____, _____.
Ce verdict a été reçu par moi le

Original signed by Coroner

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

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Verdict of Coroner's Jury / Verdict du jury du coroner

We / Nous soussignés,

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famille	Given names / Prénom
LUFT	DANIEL

Aged / Âgé(e) de 7 Years

held at / qui a été menée à 150 Frederick Street, City of Kitchener

on the / le 8th to 26th

day(s) of / (du/au) January, 2001

by / par Dr. Karen Acheson, Coroner for Ontario / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) DANIEL LUFT

2. Date and time of death / Date et heure du décès JULY 6, 2000 at 11:55 a.m.

3. Place of Death / Lieu de décès 146 Mooregate Cr., Kitchener, Ontario

4. Cause of death / Cause du décès Gunshot wounds of head and chest

5. By what means / Circonstances entourant le décès Homicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____, _____.
Ce verdict a été reçu par moi le

Original signed by Coroner

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

Office of the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury/ Verdict du jury du coroner

We / Nous soussignés, of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famile	Given names / Prénom
LUFT	DAVID

Aged / âgé(e) de 3 Months

held at / qui a été menée à 150 Frederick Street, City of Kitchener

on the / le 8th to 26th

day(s) of / (du/au) January, 2001

by / par Dr. Karen Acheson, Coroner for Ontario / coroner pour l'Ontario,

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) DAVID LUFT

2. Date and time of death / Date et heure du décès JULY 6, 2000 at 1:40 a.m.

3. Place of Death / Lieu de décès 146 Mooregate Cr., Kitchener, Ontario

4. Cause of death / Cause du décès Gunshot wound of head

5. By what means / Circonstances entourant le décès Homicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____, _____.
Ce verdict a été reçu par moi le

Original signed by Coroner

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

Office of the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury/ Verdict du jury du coroner

We / Nous soussignés, of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famille	Given names / Prénom
LUFT	PETER

Aged / âgé(e) de 2 Years

held at / qui a été menée à 150 Frederick Street, City of Kitchener

on the / le 8th to 26th

day(s) of / (du/au) January, 2001

by / par Dr. Karen Acheson, Coroner for Ontario / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) PETER LUFT

2. Date and time of death / Date et heure du décès JULY 6, 2000 at 12:00 p.m.

3. Place of Death / Lieu de décès 146 Mooregate Cr., Kitchener, Ontario

4. Cause of death / Cause du décès Gunshot wounds of head and chest

5. By what means / Circonstances entourant le décès Homicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____, _____.
Ce verdict a été reçu par moi le

Original signed by Coroner

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

Office of the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury/ Verdict du jury du coroner

We / Nous soussignés

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

of / de Region of Waterloo

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête surs le décès de:

Surname / Nom de famille	Given names / Prénom
LUFT	NICOLE

Aged / âgé(e) de 5 Years

held at / qui a été menée à 150 Frederick Street, City of Kitchener

on the / le 8th to 26th

day(s) of / (du/au) January, 2001

by / par Dr. Karen Acheson, Coroner for Ontario / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) NICOLE LUFT

2. Date and time of death / Date et heure du décès JULY 6, 2000 at 11:50 a.m.

3. Place of Death / Lieu de décès 146 Mooregate Cr., Kitchener, Ontario

4. Cause of death / Cause du décès Gunshot wound of chest

5. By what means / Circonstances entourant le décès Homicide

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____, _____.
Ce verdict a été reçu par moi le

Original signed by Coroner

PREFACE

We the Jury would like to convey our sincere condolences to the Luft family on the loss of their loved ones. We hope that the findings of this inquest have met the expectations of the family and community.

Over the course of this three-week inquest into the tragic deaths of the Luft family we have heard the testimony of 33 witnesses and reviewed 76 exhibits. We do not feel that there are any recommendations that would have prevented these deaths. We the jury all agree that, based on the evidence provided, these deaths were unpredictable by any family members, caregivers, social workers, or institutions involved with the family.

We have, however, identified some recommendations that have arisen from the evidence provided in this inquest, which we feel would reduce the risk of similar occurrences from happening in the future.

Recommendations of the Coroner's Jury in the Inquest into the Deaths of Bill Luft, Bohumila Luft, Daniel Luft, David Luft, Peter Luft and Nicole Luft

After careful consideration of all of the testimony and evidence given, we the jury have the following recommendations:

EDUCATION

Findings: One reason that was given for the resistance of treatment by a patient is due to the lack of acceptance of the diagnosis by the patient. This is created by the negative stigmatism attached by society to all mental illnesses. This social non- acceptance stems from the limited knowledge or public awareness of this disability.

1. We recommend that there be additional on-going funding provided by Ministries of Health and Community and Social Services to enhance public awareness. By utilizing the channels of advertisement, media, educational programs, school systems and existing community resources we would better reach and educate as many members of the community as possible.

2. We recommend that education on mental health be included as standard curriculum in secondary schools, as there are indications of the onset of mental illness at this age. This will assist with the awareness and understanding of these illnesses both by those suffering as well as their peers. This type of education should also be included in post secondary educational programs to enhance training in social work and related fields.

COMMUNICATION

Findings: We have found some instances where the sharing and availability of information might have been beneficial to some parties involved.

Family and Children Services/ Children's Aid Society

3. Implementation of best practice to ensure copies of messages regarding open files is given to the supervisor of the caseworker responsible for the case. This will ensure prompt response to any pertinent information obtained while a caseworker is away. Additionally all telephone messages should be returned within a 24 hour time frame.

4. Enhancement to the Fast Track software, used for queries across agencies in Ontario, to incorporate multiple possible responses for a specific name requested.

5. If an urgent referral is made to Family &Children Services/Children's Aid Society by another social service or community agency involved with the family or providing service to the family, an automatic 12-hour response time is placed on the file. There should also be a free flow of information back to the referral.

6. If a rating is given to a file at any time that is above the intervention line on the eligibility spectrum, then at minimum, family contact must be made prior to decreasing the severity of the file or closing it.

Physicians

7. Bill 159 is currently before the legislature and addresses the access of patient information between Physicians. We would like to recommend that this aspect of the bill be encouraged. This would allow for better care given to the patient by knowing some of the past illnesses that have occurred and ensure that another provider is not duplicating care.
8. We recommend that when psychiatrists are treating a patient that they promote input from the family core to build a solid therapeutic relationship needed for treatment.

TREATMENT

Findings: We have found that the resources available to assist with on going monitoring of psychiatric patients, by community agencies, are being stretched.

- We recommend that additional funding be provided by the Ministry of Health to the Canadian Mental Health Association and other community support groups to allow for appropriate monitoring and assistance for qualified patients and their families.

Regional Supervising Coroner
Central West Region
125 Delhi Street
Suite 442
Guelph ON N1E 4J5
Telephone: (519) 837-6330
Facsimile: (519) 837-6329

Coroner Superviseur Régional
Centre Ouest
125 rue Delhi
Bureau 442
Guelph ON N1E 4J5
Téléphone : (519) 837-6330
Télécopieur : (519) 837-6329

Ontario

Verdict Explanation for the Inquest into the Deaths of Bill, Bohumila, Daniel, Nicole, Peter and David Luft

Dates of Inquest:	January 8,9,11,12,15,16,17,22,23,24,25,26, 2001
Presiding Coroner:	Dr. K. Acheson
Assistant Crown Attorney:	Mr. Lowell Hunking
Investigating Officer:	Sergeant Rob Munro, Waterloo Regional Police
Coroner's Constable:	Constable Bruce Christie, Waterloo Regional Police

Persons granted Standing:

1. Luft family, represented by William Appleby
2. Ministry of Health represented by Andrew Heal
3. Perth County Children's Aid Society represented by John Sipos
4. Grand River Hospital represented by Daphne Jarvis
5. Dr. Surapaneni, Dr. Murji and Dr. Kordish represented by Darryl Ferguson
6. Family and Children's Services of Waterloo Region represented by Randall Hamel

This verdict explanation contains a brief synopsis of the evidence presented at this inquest, together with some explanatory remarks about the individual recommendations made by the jury. The sole purpose of this explanation is to assist the reader to understand the jury's recommendations, it is not intended to replace the verdict. I would like to stress that this explanation is my interpretation of the evidence and the jury's reasons.

Synopsis

William (Bill) LUFT was diagnosed with Bipolar Affective Disorder in 1983, and since that time was admitted to hospital as a voluntary and an involuntary psychiatric patient on a number of occasions. His condition could be controlled with medication, but LUFT tended to be non-compliant with his medication. He received a disability pension for his condition.

He met Bohumila KALKUSOVA on a trip to the Czech Republic, and they were married in the Czech Republic in 1993. The couple had a son, Daniel, on July 13, 1993, and a second child, Nicole, on February 25, 1995. LUFT's behaviour in the delivery room during Nicole's birth resulted in LUFT's admission as an involuntary psychiatric patient.

Bohumila left LUFT and returned to the Czech Republic in May 1997. She met another man and conceived his child. Bohumila divorced LUFT and married the father of the child she was carrying. She then reconciled with LUFT while still pregnant and returned to Canada. The child was born in Canada on April 21, 1998 and was raised as LUFT's son.

On Bohumila's return to Canada, the couple moved to Bayfield, Ontario where they lived at a rural bed and breakfast, paying reduced rent in return for maintenance work. The relationship between LUFT and the owner of the bed and breakfast soured in late 1998, leading to a series of allegations of thefts by each party, a complaint of threats against LUFT by the owner of the bed and breakfast, and the repossession of LUFT's motor home while the LUFT family was using it for a Texas vacation. LUFT filed a civil action against the owner of the bed and breakfast in January 1999, which was still outstanding at the time of his death. The bed and breakfast owner lodged a complaint against LUFT with the Children's Aid Society the day before a court appearance in the civil action and seven months after her last contact with Mts. Luft and the children. The complaint was investigated and cleared as unfounded.

In May 1999, LUFT's parents went on an extended vacation to Europe. They rented their house at 146 Mooregate Crescent, Kitchener to Bill LUFT and his family.

In late 1999, Bohumila became pregnant with her fourth child. Prenatal tests showed the child would have severely disabling medical conditions. While in a meeting with medical staff to discuss the recommendations of medical specialists, Bill LUFT talked to a social worker. He told the social worker that he had had a conversation with the fetus in utero, during which the fetus told him that there was nothing wrong with him (the fetus,) and that he found the discussion regarding the deformity extremely upsetting.

In April 2000, Bohumila was hospitalized in London due to the anticipated problems with the child. Her mother came from the Czech Republic to look after the children during her hospitalization.

On April 24, 2000, Bohumila gave birth to David LUFT by caesarean section. David had spina bifida and myelomeningocele, disabling spinal deformities.

On April 25, 2000, Bohumila expressed a concern to a social worker that LUFT was not taking his medication, and asked the social worker to contact LUFT's doctor and psychiatrist for assistance. The social worker asked Bohumila if she felt the children were at risk. She replied that LUFT had never physically abused the children, but she was concerned that he may take the children and flee. Bohumila was initially hesitant to involve Children's Aid for fear they may take the children, but eventually consented to having the social worker call the Family and Children's Services in Waterloo Region. The social worker called and briefed the Waterloo Region Family and Children's Services and asked that they call Bohumila in hospital to follow up. The social worker also called LUFT's current and past family doctors, and left a message for LUFT's psychiatrist.

Although LUFT was upset with the social worker's "interference," he spoke with his family doctor, who noted no evidence of LUFT neglecting his children. The doctor in fact noted LUFT's "devotion" to his family, and that he was dealing with his stresses "remarkably well." The doctor prescribed medication for LUFT and recommended that he call the Crisis Clinic for suggestions with regards to counseling.

LUFT attended the Crisis Clinic with Bohumila on May 1, 2000, complaining of irritability, mood swings and insomnia. LUFT denied any suicidal ideas or intent, and was concerned about the effect of his irritability and mood swings on his children. LUFT was admitted to Grand River Hospital psychiatric unit. The Crisis Clinic notified the Family and Children's Services of Waterloo Region that LUFT had been admitted, and that they were concerned as to what may happen when he was discharged.

On May 3, 2000, LUFT was discharged from Grand River Hospital. The Crisis Clinic notified Family and Children's Services that LUFT had been discharged and that there was "no immediate concern or risk." After conversation with the London social worker who had made the initial call, Family and Children's Services closed the LUFT file noting that LUFT had sought appropriate help and that intervention was no longer needed, and that intervention may "bring more harm than good to family dynamics."

On May 15, 2000 LUFT attended court in answer to an application made in October 1998 by the bed and breakfast owner to have LUFT enter into a peace bond not to contact her. The matter was resolved when LUFT and the owner of the bed and breakfast mutually agreed to enter into peace bonds not to have contact with each other.

During this time frame, LUFT was experiencing some domestic difficulties. His parents had returned from their European trip and were living in a motor home in the driveway. LUFT was behind in his rent payments and had in fact run his parents' credit cards up in their absence. LUFT felt that his parents were interfering in his children's upbringing, particularly with regards to education. LUFT felt that the public school system would be a bad influence on his children, and wanted to home school them. His mother was trying to teach the older children to read, and LUFT saw this as interference with his role as father. LUFT had also recently evicted his nephew, who had been living with them, and was experiencing difficulty with his nephew and his family as a result. His parents had arranged to sell the house to LUFT's younger brother, meaning LUFT and his family would have to find another residence. Bohumila had told LUFT that she, too, wanted to enroll their children in public school, and would leave him if the home situation did not improve.

LUFT had also accumulated considerable debt. In addition to owing over $17,000 to several creditors, four of whom considered him "delinquent," he was approximately $45,000 in debt to his father.

Sometime overnight from July 5, 2000 to July 6, 2000, LUFT killed his wife Bohumila and their children Daniel, Nicole, Peter and David before taking his own life. The sequence of events is unclear. At some point LUFT entered the bedroom that Bohumila shared with David. He struck Bohumila in the face with the handle of a saucepan that was in the

bedroom and stabbed her in the abdomen with a kitchen knife. Bohumila went downstairs where she collapsed and died of her injuries. David was stabbed in the area of the right knee likely because he was in his mother's arms when she was stabbed. David was then shot in the head with a .22 caliber rifle. Nicole was shot in the chest from the doorway of Bohumila's bedroom while she was standing in the hallway. Daniel was shot in the chest and in the head while he was in his bed, in a bedroom he shared with Nicole. Peter was shot in the chest and in the head while he was in his bed in his own bedroom. The 22 calibre rifle, that had been stored in the basement, was purchased by LUFT with his father's Firearms Acquisition Certificate in 1991.

LUFT then returned to his own bedroom and shot himself under the chin. This wound was insufficient to cause his death. He then shot himself fatally in the chest.

The Jury wrote the following preface to their recommendations:

PREFACE

We the Jury would like to convey our sincere condolences to the Luft family on the loss of their loved ones. We hope that the findings of this inquest have met the expectations of the family and community.

Over the course of this three-week inquest into the tragic deaths of the Luft family we have heard the testimony of 33 witnesses and reviewed 76 exhibits. We do not feel that there are any recommendations that would have prevented these deaths. We the jury all agree that, based on the evidence provided, these deaths were unpredictable by any family members, caregivers, social workers, or institutions involved with the family.

We have, however, identified some recommendations that have arisen from the evidence provided in this inquest, which we feel would reduce the risk of similar occurrences from happening in the future.

After careful consideration of all of the testimony and evidence given, we, the jury have the following recommendations:

EDUCATION

Findings: One reason that was given for the resistance of treatment by a patient is due to the lack of acceptance of the diagnosis by the patient. This is created by the negative stigmatism attached by society to all mental

illnesses. This social non- acceptance stems from the limited knowledge or public awareness of this disability.

1. We recommend that there be additional on-going funding provided by Ministries of Health and Community and Social Services to enhance public awareness. By utilizing the channels of advertisement, media, educational programs, school systems and existing community resources we would better reach and educate as many members of the community as possible.

   This recommendation is largely self-explanatory. The jury heard evidence from Bill's family doctor that he did not accept the diagnosis of Bipolar Disorder and did not think he needed Lithium in the winter and spring of 2000. There was some evidence to suggest that he been more accepting of the diagnosis at other times. An expert psychiatrist testified that acceptance of a diagnosis like bipolar disorder may be difficult for patients because of the significant stigma attached to mental illness in our society.

2. We recommend that education on mental health be included as standard curriculum in secondary schools, as there are indications of the onset of mental illness at this age. This will assist with the awareness and understanding of these illnesses both by those suffering as well as their peers. This type of education should also be included in post secondary educational programs to enhance training in social work and related fields.

   See the jury's explanation above.

COMMUNICATION

Findings: We have found some instances where the sharing and availability of information might have been beneficial to some parties involved.

Family and Children Services/ Children's Aid Society

1. Implementation of best practice to ensure copies of messages regarding open files is given to the supervisor of the caseworker responsible for the case. This will ensure prompt response to any pertinent information obtained while a

caseworker is away. Additionally all telephone messages should be returned within a 24 hour time frame.

The caseworker assigned to this case was away for five days. Messages about the case accumulated in her file, but her supervisor was not aware of these.

2. Enhancement to the Fast Track software, used for queries across agencies in Ontario, to incorporate multiple possible responses for a specific name requested.

   The Fast Track software was used to check on previous contacts with other childrens Aid Societies. Unfortunately, Bi was entered for Bill while Fast Track had him listed as Wi for William and Bo for Bohumila while Fast Track said Bu for Bumila. Spelling of names and use of diminutives were confounding variables in the ability of the F&CS to check for other CAS contacts.

3. If an urgent referral is made to Family &Children Services/Children's Aid Society by another social service or community agency involved with the family or providing service to the family, an automatic 12-hour response time is placed on the file. There should also be a free flow of information back to the referral.

   The F&CS received this referral from a social worker at a children's hospital. This worker had the training to recognize the important elements of risk. I think the jury is pointing out that a referral from a professional should receive priority because the professional has in effect performed a screening function before calling.

4. If a rating is given to a file at any time that is above the intervention line on the eligibility spectrum, then at minimum, family contact must be made prior to decreasing the severity of the file or closing it.

   *The F&CS originally rated this case as a **B** meaning that intervention was required. They did not interview any of the family prior to changing the rating to a **C** and closing the file.*

<u>Physicians</u>

1. Bill 159 is currently before the legislature and addresses the access of patient information between Physicians. We would like to recommend that this aspect

of the bill be encouraged. This would allow for better care given to the patient by knowing some of the past illnesses that have occurred and ensure that another provider is not duplicating care.

The family doctor testified that Bill refused to sign a consent for release of psychiatric records so that the doctor did not know the basis for the diagnosis of bipolar disorder. At that time, Bill did not accept the diagnosis and stopped taking Lithium. If the family doctor had been able to review the medical record, he might have been able to help Bill deal with his denial and his problems with Lithium and possible side effects.

2. We recommend that when psychiatrists are treating a patient that they promote input from the family core to build a solid therapeutic relationship needed for treatment.

   This recommendation arises from the expert testimony that families need to be in communication with the psychiatrist to enhance and support the patient's treatment. In this case, Bill saw a psychiatrist in Kitchener on only one occasion as an outpatient. His attendance at appointments was poor because he had to attend court in Goderich for a civil case. He had a short admission to hospital, but was determined to leave because his newborn son was having surgery in London and he wanted to be there. He was not found to be a danger to himself at that time (nearly three months before his suicide) so he left. In this case, there was very little opportunity for Bill's family and psychiatrist to communicate.

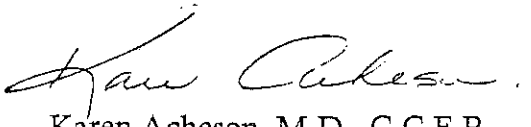
TREATMENT

Findings: We have found that the resources available to assist with on going monitoring of psychiatric patients, by community agencies, are being stretched.

1. We recommend that additional funding be provided by the Ministry of Health to the Canadian Mental Health Association and other community support groups to allow for appropriate monitoring and assistance for qualified patients and their families.

The Luft family was struggling with debt, (largely induced by Bill's unrealistic business plans and failures which likely incurred during manic/hypomanic episodes), the responsibility of caring for four children seven years of age and under, the grief and responsibility for a newborn with severe problems that meant that he might never walk and needed frequent medical visits in Kitchener and London for years, and marital difficulties of long standing. Mrs. Luft had to deal with all of these problems plus the mental illness of her husband and his tendency to become psychotic when the stresses in his life became severe.

In closing, I would like to stress again that this explanation is written solely for the purpose of assisting the reader to understand the verdict. The comments that I have made are my recollections of the evidence and are not put forward as actual evidence. As in all inquests, a court reporter recorded the testimony of all witnesses, the summation of the assistant crown attorney and my charge to the jury. If any party wishes to have a transcript made, the court reporter was Marbrae Paralegal Services, 630-50 Queen Street North, Kitchener, Ontario. N2H 6P4, 519-745-4020.



Karen Acheson, M.D., C.C.F.P.
Regional Coroner South Georgian Bay,
Presiding Coroner