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 the undersigned / Nous soussigné

Tim Kacurov	of / de	*Toronto*	
Carol Kenney	of / de	*Toronto*	
Wayne Weir	of / de	*Toronto*	
Anne Marie Parker	of / de	*Toronto*	
Vincenza Leo	of / de	*Toronto*	

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
Williams	*Wayne Rick*

aged / âgé(e) de *24* held at / qui a été menée à *the Coroner's Inquest Courts, 15 Grosvenor Street, Toronto, Ontario*

from the / le *8th. day of May* To the / (du/au) *9th. day of June* 20 *00*

By / Par Dr. *William Lucas* 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)	*Wayne Rick Williams*
2.	Date and time of death / Date et heure du décès	*June 11, 1996 at 6:24 am.*
3.	Place of Death / Lieu de décès	*Centenary Health Centre, Toronto*
4.	Cause of death / Cause du décès	*Multiple gunshot wounds*
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 / Ce verdict a été reçu par moi le *9th.* day of *June* 20 *00*

Original signed by Coroner

Distribution: Original – Regional coroner for fowarding to Chief Coroner / L'original - coroner de la région pour transmission ai coroner en chef

Copy – Crown Attorney / Copie – Procureur de la Couronne

CC 010 (Rev. 06 / 89)

Jury Recommendations Concerning the Death of:

Wayne Rick Williams

The following recommendations are not presented in any particular order of priority.

Ministry of Health and Long-Term Care

1. The Ministry of Health and Long-Term Care should ensure that a range of mental health crisis services be available throughout the Greater Toronto Area and that the information regarding these services be readily available to the public.

   Rationale:
   The evidence in this inquest indicates that the number of services available were insufficient and that it would have been helpful to know about all the services available.

2. The Ministry of Health and Long-Term Care require hospitals to develop protocols to ensure that:

   (a) their staff, including doctors, are aware of all available mental health services such as case managers, assertive community treatment teams, mobile crisis units, crisis centres and the hospitals which have 24 hour enhanced mental health emergency crisis hospital services;

   (b) their staff, including doctors, fully inform patients and families of patients of these available services;

   (c) all mentally ill patients are given the option to be linked up with case managers;

   (d) discharge instructions should be signed by the patient or caregiver and the person who gave the instructions;

   (e) if an individual discharges himself or herself against medical advice, that the person or caregiver, is offered all information respecting available resources and offered assistance in accessing them.

   Rationale:
   The evidence showed that the hospital is a common place that people turn to for help and information. This would make the hospital a central location to provide people with information in the area of mental health services. Pamphlets should be available in emergency rooms and doctor's offices.

3. The Ministry of Health and Long-Term Care should continue to support various initiatives to educate consumer/survivors, affected family members, the police, and health care providers about relevant mental health law and the roles and responsibilities of the various players in the mental health system.

   Rationale:
   The existing legislation is complex and could lead to possible misinterpretation in its application.

4. The Ministry of Health and Long-Term Care should appoint a coordinator to facilitate the current ad hoc efforts to integrate responses of the various mobile crisis intervention services with the crisis response of the Toronto Police Service.

5. It is recommended that a case manager or primary health care provider be required to specifically advise a consumer/survivor suffering from a major mental illness characterized by periodic psychotic episodes as to the existence of powers of attorney for personal care.

6. It is recommended that persons receiving their medication through injections receive written information concerning the medication and potential side effects and risks associated with the medication.

   Rationale:
   Prescriptions received from a pharmacist are accompanied with written information. Evidence showed that the family may not have had a full appreciation of the side effects from the medication being administered.

Toronto Police Services and Chief of Police

7. It is recognized that the Toronto Police Services Board and the Chief of Police have made the Crisis Resolution Course mandatory for all officers since March of 1999 and that officers have continued to be trained since that time. We suggest that the Board and the Chief assign a high priority to the continued delivery of this course until all officers have been trained. We also recommend the implementation of an ongoing mandatory refresher course.

   Rationale:
   Evidence in this inquest suggested that this course is a good one and that it can only be beneficial to all Police Officers.

8. When a police officer involved in an SIU incident is excused from doing his or her memo book notes before the end of a shift, there should be a written record made by the person who excuses the officer from making the notes, setting out the reason for the delay.

Toronto Police Services and The Solicitor General

9. The Toronto Police Service should continue research and testing of non-lethal weapons and report developments annually to the Police Services Board. The Solicitor General should authorize the Toronto Police Service, in addition to the Ottawa Police Service, to conduct a pilot project regarding the operational capabilities and effectiveness of the M26 taser.

   Rationale:
   Evidence of greater potential for usage in Toronto and no harm in getting more accurate statistical information.

Health Canada

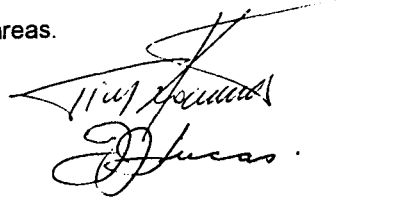
10. Health Canada should appoint a coordinator to monitor the amount of dollars dedicated annually to research into the causation and treatment of schizophrenia, it being recognized that significant research funding flows from federal funding sources.

    Rationale:
    We support Health Canada's initiatives in funding schizophrenia research. Due to the fact that funding is provided through both federal and provincial agencies, federal granting bodies would be aware of all funding a researcher would have or has had in the past.

We, the jury, acknowledge that some positive steps have already been taken to address some issues that arose from this inquest. Therefore, we are not going to duplicate recommendations from previous inquests in the areas of:

- additional safe beds and housing
- case management services
- implementation of mobile crisis teams
- mandatory Crisis Resolution training
- continued involvement of consumer/survivors groups

We encourage and support the ongoing efforts and initiatives in these areas.



WAYNE RICK WILLIAMS INQUEST

VERDICT EXPLANATION

Location:	15 Grosvenor Street
Dates of Inquest:	May 8th – June 9th, 2000
Coroner's Counsel:	Mr. Michael Blain
Investigating Officer:	Detective Mark Johnstone, OPP
Coroner's Constable:	PC William Rands, OPP
Court Reporter:	Liz Ritzer 73 Brooklawn Avenue, Toronto, ON M1M 2P7 Tel: (416) 266-3323

Counsel Representing Parties with Standing:

1. Williams' family represented by Julian Falconer and Julian Roy
2. Chief Julian Fantino and Toronto Police Services Board represented by Jane Egan
3. Toronto Police Services Officers Harrison, Hayford, Archer, Bourgeois, and Court represented by Joanne Mulcahy
4. Ministry of Health and Long Term Care represented by Janice Blackburn
5. Queen Street Patient Council represented by Suzan Fraser
6. Drs. Kramer, Moran, and Zakaria represented by Brian Butler and Nada Nicola

I intend to give a brief summary of the circumstances surrounding Mr. Williams' death as well as a brief synopsis of the issues explored at the inquest. Where it is felt to be of potential assistance, I will also comment on my understanding of the reasons behind the jury's recommendations. I wish to stress that it will be my own interpretation of the evidence and of the jury's reasoning. It is not intended to replace the actual evidence presented to the jury but is provided to assist the reader in interpreting the context in which their verdict and recommendations were made, so that they can be better understood. It is <u>not</u> intended to replace the jury's verdict.

Wayne Williams was born in May 1972. In February 1994, he began to exhibit strange behaviors and was taken to the local hospital emergency department where he was assessed, but not admitted.

Approximately one month later, he was exhibiting aggressive behavior, so police were requested to attend. Mr. Williams was taken to the Emergency Department of the local hospital in handcuffs, and was admitted as an involuntary patient. He was assessed and discharged the following day. Within eight days he was again returned to hospital, this time being admitted for a seven day stay. He signed himself out of hospital against medical advice. In April, he was re-admitted to hospital as an involuntary patient for a brief stay. In June, he was re-admitted twice and was started on the anti-psychotic medication, Fluanxol. At this time, he was diagnosed with schizophrenia.

Mr. Williams next required hospitalization in July of 1995, after apparently being off medication for a few weeks. His parents subsequently made arrangements for him to live independently in an apartment. They continued to maintain contact with him however, with his father taking him shopping every weekend.

During this time, arrangements had been made for Mr. Williams to remain under the care of his family doctor and a psychiatrist on an out-patient basis. However, in January of 1996, he discontinued visits to his family doctor's office where he was receiving medication injections. His family was not aware that he was no longer receiving care or supervision.

In March of 1996, he indicated to his family that he was not feeling well and was experiencing abnormal bodily sensations. He was compliant with his parent's suggestion to be taken to the local emergency department for assessment. His family anticipated he would be admitted to hospital. However, after a brief assessment, he was discharged from the Emergency Room. Evidence at the inquest was conflicting regarding what arrangements for follow-up were discussed at that time.

On the morning of June 11th, 1996, at approximately 5:38 a.m., police were notified that a male subject, later determined to be Wayne Williams, was damaging car windows in a residential area of Scarborough. Police were alerted that the subject might be armed with a baseball bat or a tire iron.

The first officer to arrive at the scene observed Mr. Williams to take out a knife from one of his pockets and hold it up. As the officer exited and came around to the front of his vehicle, he observed Mr. Williams to take out a second knife and hold it up in a menacing fashion. The officer withdrew his firearm and issued a police challenge. Other officers arrived as support units shortly after the first officer on scene. They also drew their firearms. Despite police commands to stop and drop the weapons, Mr. Williams advanced towards an officer. As he did, he was shot several times, falling to the ground.

Officers administered first aid to Mr. Williams while awaiting the arrival of an ambulance. Mr. Williams was subsequently transported to hospital where shortly after arrival, he was pronounced dead.

The jury heard evidence from 22 witnesses over a period of 18 days. Preparation and arguments and submissions took place over 3 days. There were a total of 32 exhibits tendered.

VERDICT OF CORONER'S JURY

The jury determined the following:

1.	Name of Deceased:	Wayne Rick Williams
2.	Date and Time of Death:	June 11th, 1996 at 6:24 A.M.
3.	Place of Death:	Centenary Health Centre, Toronto, ON
4.	Cause of Death:	Multiple Gunshot Wounds
5.	By What Means:	Homicide

(Coroner's Note: The jury was carefully instructed that a finding of homicide by a Coroner's Jury is a finding of fact, not a conclusion in law. It is a neutral term that assigns no blame or responsibility for the death)

JURY RECOMMENDATIONS

MINISTRY OF HEALTH AND LONG-TERM CARE

Recommendation #1

"The Ministry of Health and Long-Term Care should ensure that a range of mental health crisis services be available throughout the Greater Toronto Area and that the information regarding these services be readily available to the public".

Rationale: The evidence in this inquest indicates that the number of services available were insufficient and that it would have been helpful to know about all the services available.

Coroner's Comments

Mr. Williams received virtually all of his mental health services outside the former Metropolitan Toronto area. Prior to his death in June 1996, the number of services available to deal with individuals in crisis were limited. Evidence regarding new services that have become available throughout the Greater Toronto Area since that time was of great interest to the jury. However, general knowledge about these services and resources may not be widely known or appreciated by members of the public who have not had a great deal of contact with mental health services.

Recommendation #2

"The Ministry of Health and Long-Term Care require hospitals to develop protocols to ensure that:

(a) their staff, including doctors, are aware of all available mental health services such as case managers, assertive community treatment teams, mobile crisis units, crisis centres and the hospitals which have 24 hour enhanced mental health emergency crisis hospital services;
(b) their staff, including doctors, fully inform patients and families of patients of these available services;
(c) all mentally ill patients are given the option to be linked up with case managers;
(d) discharge instructions should be signed by the patient or caregiver and the person who gave the instructions;
(e) if an individual discharges himself or herself against medical advice, that the person or caregiver, is offered all information respecting available resources and offered assistance in accessing them".

Rationale: The evidence showed that the hospital is a common place that people turn to for help and information. This would make the hospital a central location to provide people with information in the area of mental health services. Pamphlets should be available in emergency rooms and doctor's offices.

Coroner's Comments

In March of 1996, Mr. Williams was taken to the local hospital emergency department for assessment of his mental disorder. After a brief visit in the ER, he was discharged for out-patient follow-up. It is unclear whether he was referred to a crisis team for further assessment, or whether he was expected to follow up with his family physician.

The jury heard evidence that there are now a variety of different resources available within the community to assist those suffering from mental illness or who may be in crisis. It is therefore important that hospitals and caregivers be knowledgeable about these resources or that appropriate referrals can be made and information disseminated.

Recommendation #3

"The Ministry of Health and Long-Term Care should continue to support various initiatives to educate consumer/survivors, affected family members, the police, and health care providers about relevant mental health law and the roles and responsibilities of the various players in the mental health system".

Rationale: The existing legislation is complex and could lead to possible misinterpretation in its application.

Coroner's Comments

Evidence was presented by an expert who had been associated with the Mental Health Law Education Project, responsible for educating the public and healthcare providers in various aspects of current mental health law. The project had been temporarily suspended once amendments to the Mental Health Act were introduced. The jury believes that the educational initiative was an excellent one and should be continued.

Recommendation #4

"The Ministry of Health and Long-Term Care should appoint a coordinator to facilitate the current ad hoc efforts to integrate responses of the various mobile crisis intervention services with the crisis response of the Toronto Police Service".

Coroner's Comments

Various independent mobile crisis intervention services exist in the City of Toronto, and new programs are being developed. Because the Toronto Police Service has traditionally been involved as primary responders to individuals in crisis, the Police Service has currently two crisis response team pilot projects, working in cooperation with other existing crisis intervention services within the City including the Gerstein Centre and New Dimensions in Community Living. Although there is an interest in coordinating these services, to date this has not come about. The jury is suggesting that the Ministry of Health should take the initiative to oversee, coordinate and integrate the initiatives that currently exist.

Recommendation #5

"It is recommended that a case manager or primary health care provider be required to specifically advise a consumer/survivor suffering from a major mental illness characterized by periodic psychotic episodes as to the existence of powers of attorney for personal care".

Coroner's Comments

The jury heard evidence concerning the Healthcare Consent Act and the Substitute Decisions Act. While a person is capable, he may designate a Power of Attorney for personal care to make decisions for him when he is no longer capable. The jury heard evidence that many individuals may not understand this fact, or that this may have implications to express their capable wishes at a time when they are not capable. The jury therefore feels that this should be explained to them.

Recommendation #6

"It is recommended that persons receiving their medication through injections receive written information concerning the medication and potential side effects and risks associated with the medication".

Rationale: Prescriptions received from a pharmacist are accompanied with written information. Evidence showed that the family may not have had a full appreciation of the side effects from the medication being administered.

Coroner's Comments

Mr. Williams was receiving his anti-psychotic medication via injection. From the evidence presented, it was not clear how much detail or discussion had taken place with either Mr. Williams or his family regarding the potential side effects or complications that might arise from such medication. Understanding that many retail pharmacies provide this information

in a written format when oral prescriptions are received, they felt that similar information should be available for depot (injectable) medications.

TORONTO POLICE SERVICES AND CHIEF OF POLICE

Recommendation #7

"It is recognized that the Toronto Police Services Board and the Chief of Police have made the Crisis Resolution Course mandatory for all officers since March of 1999 and that officers have continued to be trained since that time. We suggest that the Board and the Chief assign a high priority to the continued delivery of this course until all officers have been trained. We also recommend the implementation of an ongoing mandatory refresher course".

Rationale: Evidence in this inquest suggested that this course is a good one and that it can only be beneficial to all Police officers.

Coroner's Comments

Evidence was presented that a recommendation from the Donaldson Inquest resulted in the establishment of a Crisis Resolution Course. Unfortunately, due to budget constraints, this course was later discontinued. During the Yu Inquest, the course was re-established and is currently being delivered on a regular basis with a view to training all officers by the end of 2001. The consensus of police trainers is that this is an excellent course and the jury is endorsing its continued delivery with the suggestion that once all officers have been exposed to this course, that an on-going refresher course format be developed.

Recommendation #8

"When a police officer involved in an SIU incident is excused from doing his or her memo book notes before the end of a shift, there should be a written record made by the person who excuses the officer from making the notes, setting out the reason for the delay".

Coroner's Comments

Evidence was presented that officers involved in this particular incident were excused from completing their memo book notes by a senior officer. These notes would normally be expected to be completed in compliance with the Police Act and regulations. In order to reduce concerns about the integrity and credibility of the officers, it was felt that a written record, prepared by the senior officer would provide clarification and prevent any sinister speculation as to why the notes were not concluded in a timely fashion.

TORONTO POLICE SERVICES AND THE SOLICITOR GENERAL

Recommendation #9

"The Toronto Police Service should continue research and testing of non-lethal weapons and report developments annually to the Police Services Board. The Solicitor General should authorize the Toronto Police Service, in addition to the Ottawa Police Service, to conduct a pilot project regarding the operational capabilities and effectiveness of the M26 taser".

Rationale: Evidence of greater potential for usage in Toronto and no harm in getting more accurate statistical information.

Coroner's Comments

The jury is encouraging the Toronto Police Services to continue its pursuit of alternatives to lethal force. They were made aware of a pilot project, recently approved by the Solicitor General for the Ottawa Police Service to test the effectiveness of the M26 taser. The larger population in Toronto creates the potential for more circumstances to arise where such non-lethal force may be utilized. The jury is therefore urging the Solicitor General to work cooperatively with the Toronto Police Service to expand the pilot project to involve the Toronto Police Service.

HEALTH CANADA

Recommendation #10

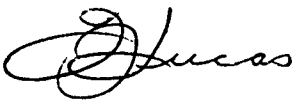
"Health Canada should appoint a coordinator to monitor the amount of dollars dedicated annually to research into the causation and treatment of schizophrenia, it being recognized that significant research funding flows from federal funding sources".

Rationale: We support Health Canada's initiatives in funding schizophrenia research. Due to the fact that funding is provided through both federal and provincial agencies, federal granting bodies would be aware of all funding a researcher would have or has had in the past.

Coroner's Comments

Schizophrenia statistically affects 1% of the population. It therefore has a major social and financial impact on society. Research funding into cause and treatment of schizophrenia should be monitored by a central agency to ensure optimum and efficient use of funding into research.

In closing, I would stress once again, that this document has been prepared solely for the purpose of assisting the reader in understanding the inquest jury's verdict and recommendations. It does not replace the verdict and recommendations, but rather consists of my comments and recollections of the evidence presented, on which the jury based their conclusions. Should any party feel that my recollection or interpretation has been incorrect, kindly bring the matter to my attention so that the error might be appropriately corrected.



William J. Lucas, MD., C.C.F.P.
Regional Coroner for Toronto