The use of mechanical restraints in psychiatric facilities, as well as the possible relationship between pulmonary embolism and restraint use, was explored in detail during a recent coroner’s inquest.\(^1\) The inquest was held into the death of an in-patient detained on a forensic mental health unit at a psychiatric facility pursuant to a disposition of the Ontario Review Board. Prior to this patient’s unfortunate death, there was an acute decompensation of his psychiatric condition that included a violent attack on the hospital staff. The patient was placed in four-point mechanical restraints and, tragically, died six days later.

During the inquest the coroner’s jury heard from health care practitioners involved in the treatment and care rendered to this patient, as well as from experts retained by the coroner. This jury concluded that the patient died of natural means as a result of “acute pulmonary thromboembolism in a man with medical restraint”. The jury rendered an extensive list of recommendations.

The recommendations resulting from this inquest, while specifically applicable to schedule 1 psychiatric facilities, may also be of interest to other healthcare organizations utilizing restraints in their treatment of patients and clients. While the Hospital’s efforts to monitor and reduce restraint use were commended during the inquest itself, a dominant theme of the recommendations is that health care facilities are encouraged to move toward a restraint free environment. This is consistent with the principles guiding the use of restraints set out in both the legislation and common law in Ontario.

The specific recommendations by the coroner’s jury are directed at various organizations, including schedule 1 psychiatric facilities, and address the use of mechanical restraint as well as physical, chemical and environmental (seclusion) restraint.

These recommendations include:

- considering alternatives to physical restraint and using restraint for the shortest period of time possible
- tracking episodes of physical restraint
- conducting in-person physician assessments of the restrained patient’s physical health every 24 hours

\(^1\) Inquest into the Death of Jeffery James, verdict received on October 10, 2008.
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- ambulating the patient every 8 hours of continuous restraint where this can be safely accomplished
- reviewing, by an external source (i.e. a physician who is not on the unit), the use of restraints every 72 hours
- conducting a debrief following restraint use

Significantly, this coroner’s jury recommended that the Office of the Chief Coroner conduct inquests into the deaths of psychiatric patients who die while in mechanical restraint, commencing October 10, 2008. Such inquests are discretionary under the *Coroner’s Act*, which cannot be changed without legislative amendment. In recent years this discretion was challenged as being discriminatory, as inquests are mandatory into the death of prisoners in custody. The Ontario Courts have determined that the provision of the *Coroner’s Act* that allows the Coroner discretion in whether to hold an inquest into the death of a psychiatric patient is not discriminatory. What is not known is how the Office of the Chief Coroner will choose to exercise this discretion, particularly given this recent coroner’s jury recommendation.

This coroner’s jury also made several recommendations about the role of The Psychiatric Patient Advocate Office (PPAO), including that rights advice be available 24 hours a day, 7 days a week at all Schedule 1 psychiatric facilities. These recommendations also suggest an expanded role for the Patient Advocates from the PPAO, as well as more institutional independence from the Ministry of Health & Long Term Care for the organization itself.

Other organizations toward which recommendations have been directed by this coroner’s jury include: the Registered Nurses Association of Ontario, for the development of a nursing best practice guideline for the use of restraints in psychiatric patients; Accreditation Canada, to develop standards around reporting and practices for the use of mechanical restraints with psychiatric patients; the Ministry of Health and Long-Term Care, the Centre for Forensic Sciences Toxicology Section, the City of Toronto Fire Department; the Ontario Review Board and the Local Health Integration Networks.

**FINAL COMMENT**

The scope of the recommendations is very broad and advocates a multi-faceted approach to restraint reduction in accordance with leading international initiatives. Psychiatric facilities would be well advised to review the use of restraints in light of these recommendations.

The jury’s recommendations are available on-line at http://www.utopos.net/words/jamesinquest.pdf. Please feel free to contact us to obtain a copy.

Patrick Hawkins and Tanya Goldberg represented the Centre for Addiction and Mental Health at the James Inquest. They may be reached directly at 416.367.6065 and 416.367.6002, respectively, for further information.

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