



Office of
The Chief
Coroner

Bureau du
coroner
en chef

The Coroner's Act - Province of Ontario / Loi sur les coroners - Province de l'Ontario

02009-21

Verdict of Coroner's Jury Verdict du jury du coroner

We the undersigned _____ of Sault Ste. Marie
 Nous soussigné _____ de Sault Ste. Marie
 _____ of Sault Ste. Marie
 _____ of Sault Ste. Marie
 _____ of Sault Ste. Marie
 _____ of Sault Ste. Marie

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

Sumame / Nom de famille Robertson	Given names / Prénom Christopher Kelly
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aged **24** held at **Sault Ste. Marie Court House**, Ontario
 âgé(e) de qui a été menée à

from the **20th of April** to the **21st of April** 20 **09**
 du a la

By **Dr. Shelagh McRae** Coroner for Ontario
 Par coroner pour l'Ontario

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

- | | |
|--|---|
| 1. Name of deceased
Nom du (de la) défunt(e) | Christopher Kelly Robertson |
| 2. Date and time of death
Date et heure du décès | 9:17AM, July 28, 2007 |
| 3. Place of Death
Lieu de décès | Sault Area Hospital, Sault Ste. Marie, Ontario |
| 4. Cause of death
Cause du décès | Asphyxia by hanging |
| 5. By what means
Circonstances entourant le décès | Suicide |

Original signed by: Foreman/Président du jury _____

 Original signed by Jurors/Jurés

The verdict was received on the **21st** day of **April** 20 **09**
 Ce verdict a été reçu par moi le

 Original signed by Coroner

Inquest into the death of:
Christopher Kelly Robertson

JURY RECOMMENDATIONS

To the Ministry of Community Safety and Correctional Services:

- 1. All cells at the Algoma Treatment and Remand Centre be renovated to remove the ability of an inmate to hang himself using the existing bars and hinges. Failing this, inmate activity at doors be monitored by security cameras.*
- 2. Admissions forms be completed cooperatively by the admissions officer and the health care official so that an inmate's health and emotional status be observed and discussed jointly before cell assignment is considered.*
- 3. That all staff, particularly health care and admissions staff, receive extensive and on-going training on suicide awareness, including the use of mock situations and role playing to provide staff with more realistic experiences.*
- 4. That a policy be developed to more accurately allow staff to utilize the suicide screening tool in identifying low risk, high risk and no risk individuals at the time of their admission.*
- 5. That written procedures be developed to log any information received by telephone from an outside agency, including the name of the caller, the agency represented, the time of the call, and the purpose of the call, and that such information be conveyed to the appropriate level of staff.*
- 6. That verbal communication of such information be supported by written or electronic follow-up so that all involved partners be made aware of pertinent information, especially as it pertains to new admissions.*
- 7. That a review of information sharing be conducted and a protocol be developed, among the Algoma Treatment and Remand Centre, all area police services, social agencies such as the Canadian Mental Health Association, the Sault Area Hospital, etc. in order that all pertinent information regarding the inmate be available to the admissions and health personnel.*

VERDICT EXPLANATION

Name of the Deceased: Christopher Kelly ROBERTSON

Dates of Inquest: April 20th & 21st, 2009

Location of Inquest: Sault Ste. Marie Courthouse, Sault Ste. Marie

I intend to give a brief synopsis of the issues presented at this inquest and explain in some detail the reasons for the Jury's recommendations. I would like to stress that much of this will be my own interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to better understand the verdict and the recommendations of the jury and is not intended to replace the jury's verdict

Participants

Coroner's Counsel

Ms. N. Komsa
Crown Attorney, Sault Ste. Marie

Investigation Officer

D/C. S Gjos
Sault Ste. Marie OPP

Coroner's Constable

Const. J. Nickle
Sault Ste. Marie OPP

Court Reporter

Ms. R. Wing
P.O, Box 4196
41 Taylor Street
Bruce Mines
ON. P0R 1C0

Parties with Standing:

Represented by

Ministry of Community Safety and Correctional
Services

Ms. N. Osadchy
Ministry of the Attorney General
77, Grenville Street
Toronto M5S 1B3

Summary of the Circumstances of the Death:

Christopher Robertson was remanded to the Algoma Treatment and Remand Centre after being arrested for robbing the same convenience store three times in a single afternoon. He had a history of psychiatric illnesses and drug abuse and was on multiple medications. After assessments by admissions and nursing staff, he was placed alone in a small overflow cell away from the main confinement areas. During rounds the next morning he was found hanging by a strip of torn blanket tied to the bars of his cell at the door hinge. Resuscitative efforts were unsuccessful.

The inquest sat for two days, 11 witnesses were heard and 16 exhibits were entered.

Verdict of the Coroner's Jury:

The jury determined the following:

- | | |
|----------------------------|---|
| 1. Name of the Deceased: | Christopher Kelly Robertson |
| 2. Date and Time of Death: | July 28, 2007, 9:17 am |
| 3. Place of Death: | Sault Ste. Marie Area Hospital
Sault Ste. Marie, Ontario |
| 4. Cause of Death: | Asphyxia by Hanging |
| 5. By What Means: | Suicide |

Jury Recommendations:

To the Ministry of Community Safety and Correctional Services

1. All cells at the Algoma Treatment and Remand Centre be renovated to remove the ability of an inmate to hang himself using the existing bars and hinges. Failing this, inmate activity at doors be monitored by security cameras.

Coroner's comment:

The jury learned that the regular cells in the generally occupied portion of the jail had solid doors and walls. The older overflow cells such as the one which housed Mr Robertson were barred, the strip of blanket he used to hang himself was tied to the intersection of door hinge and bar.

2. Admissions forms be completed cooperatively by the admissions officer and the health care official so that an inmate's health and emotional status be observed and discussed jointly before cell assignment is considered.

Coroner's comment:

The admissions officer indicated on his form that Mr Robertson had attempted suicide two days before being arrested. That form did not go with him to the nurse who subsequently assessed him, nor did they discuss his case.

3. That all staff, particularly health care and admissions staff, receive extensive and on-going training on suicide awareness, including the use of mock situations and role playing to provide staff with more realistic experiences.
4. That a policy be developed to more accurately allow staff to utilize the suicide screening tool in identifying low risk, high risk and no risk individuals at the time of their admission.

Coroner's comment:

While she had had the standard training in suicide risk that all staff received, the nurse who assessed Mr Robertson testified that she had rarely (if ever) used the suicide assessment tool available to her. The jury was told by several witnesses that suicide alert is high risk (security clothing, segregation, continuous watch) or not at all. The jury felt that there should be some intermediate (low risk) protocol with closer monitoring of persons such as Mr Robertson.

5. That written procedures be developed to log any information received by telephone from an outside agency, including the name of the caller, the agency represented, the time of the call, and the purpose of the call, and that such information be conveyed to the appropriate level of staff.
6. That verbal communication of such information be supported by written or electronic follow-up so that all involved partners be made aware of pertinent information, especially as it pertains to new admissions.

Coroner's comment:

*A worker from the Canadian Mental Health Association interviewed Mr Robertson while he was awaiting his bail hearing. Mr Robertson told him that he would "f***ing kill" himself if he was remanded into custody. The worker called the jail to alert them and the nurse who took the message verbally relayed to his co-worker that there was a concern about suicidality. There was no documentation of the call except for some scribbled notes on a blotter (mostly a list of medications). The operations manager who made the decision on where Mr Robertson was to be placed did not hear of the threat.*

7. That a review of information sharing be conducted and a protocol be developed, among the Algoma Treatment and Remand Centre, all area police services, social agencies such as the Canadian Mental Health Association, the Sault Area Hospital, etc. in order that all pertinent information regarding the inmate be available to the admissions and health personnel.

Coroner's comment:

The police who arrested Mr Robertson after the robberies had also picked him up a few days earlier after a friend called saying he was planning to commit suicide. The information that he had recently had an assessment under the Mental Health Act was not conveyed to the jail.

Closing Comment:

In concluding this explanation I would stress again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury's verdict. The comments regarding the evidence are my personal recollection of the same and are not put forward as actual evidence. If any party feels that there has been a gross error in my recollection of the evidence or a conclusion of the jury, I would appreciate that the error is brought to my attention for any corrections to be made by myself.

Respectfully submitted,



Shelagh McRae MD CCFP FCFP
Presiding Coroner
Manitoulin District

April 26, 2009