Verdict Explanation

Mladen (Steve) Mesic Inquest
June 2 - 16, 2014
John Sopinka Courthouse
Courtroom #704
45 Main Street East
Hamilton

Opening Comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

Participants:

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Summary of the Circumstances of Death:

Mladen (Steve) Mesic was forty-five years old and residing in Hamilton at the time of his death. He had been off work for medical reasons for an extended period of time. He had recently learned that he was to be a father and was anxious that he may not make a good parent. As his return to work date approached, he appeared to become increasingly despondent, encountered difficulties sleeping and his wife noticed a significant change in his mood. Three days prior to his death he had ingested an excessive amount of alcohol mixed with medications. His wife was concerned for his well-being and called for an ambulance which took him to St. Joseph's Healthcare Hamilton for an evaluation. He was admitted for evaluation and treatment, initially as an involuntary patient on a *Mental Health Act* Form 1.

Within the required time Mr. Mesic was assessed by a physiatrist and the Form 1 was allowed to expire, however he agreed to stay at the hospital as a voluntary patient. He appeared to do reasonably well with the treatment in hospital although some nurses' notations suggest he was still having some suicidal thoughts. As a voluntary patient he had the right to leave the ward. On one occasion the evening before his death he accompanied his wife to her car off hospital grounds before returning to the hospital. There did not appear to be any indication that he was resistant to treatment, non-compliant or would leave the ward without the intent to return.

On June 3rd, 2013 Mr. Mesic had a telephone conversation with his wife early in the morning. Shortly afterwards he exited the building and proceeded to walk south up the street in the general direction of his residence. Almost immediately upon exiting the hospital Mr. Mesic watched a bus approaching down-bound on the Hamilton Mountain Access and, with what was described as a very purposeful intent, stepped in front of the bus with his arms outstretched. He was knocked down, but got up and left the scene on foot despite the bus driver requesting that he stay on the scene. He began again to walk up the access.

Less than an hour later, an individual matching the description of Mr. Mesic appeared to purposefully run in front of an approaching van on the Lincoln Alexander Parkway. The driver of the van swerved and was able to avoid hitting him.

A series of '911' calls came in and a police officer from the Hamilton Police Service was dispatched to investigate. He arrived within a few minutes and spotted Mr. Mesic walking on the south shoulder on the parkway. The officer approached Mr. Mesic in his cruiser on the off-ramp exiting the parkway and attempted to engage him in conversation. There was minimal interaction and Mr. Mesic walked away. The officer was uncertain if an infraction had occurred and radioed for assistance. A second officer arrived on-scene and both officers proceeded to follow Mr. Mesic on foot. They entered a wooded

area behind some townhouses and while the officers were discussing what they should do, a disturbance was heard nearby and both officers went into the brush to investigate.

Mr. Mesic was spotted apparently attempting to break into a residence with a shovel. The officers were not aware at the time that the home involved was actually Mr. Mesic's residence. Questions were put to him with no verbal response. Instead, he approached the officers aggressively with the shovel in-hand, crawled under a fence and continued to advance towards the officers' position. He was holding the shovel in a manner the officers reported to resemble preparation for a "baseball bat swing". The officers testified that the terrain made it difficult for them to safely withdraw. Verbal commands were given to Mr. Mesic to drop the shovel and when the distance closed to what was perceived as significantly threatening, shots were fired by both officers. Mr. Mesic initially appeared unfazed, but turned and walked a short distance away before collapsing to the ground.

The officers attended to him and provided cardiopulmonary resuscitation (CPR) until Emergency Medical Services arrived. Resuscitative efforts were terminated shortly thereafter and Mr. Mesic was pronounced dead.

The jury sat for eleven days, during which time they heard evidence from eighteen witnesses, reviewed thirty-nine exhibits and visited the scene of the death. The jury delib**erated for five** hours in reaching their verdict.

Verdict:

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Name of Deceased:	**Mladen (Steve) Mesic**
Date and Time of Death:	**Friday June 7th, 2013 at 9:40 a.m.**
Place of Death:	**Southwest corner of Upper Wentworth and the Lincoln Alexander Parkway**
Cause of Death:	**Multiple Penetrating Gunshot Wounds of the Torso**
By What Means:	**Undetermined**

Coroner's comment:
The manner of death (i.e., 'By What Means') is classified as Homicide when the death resulted directly from the actions of another person. The jury heard compelling evidence that suggested Mr. Mesic's encounter with police may have represented an attempt at Suicide on his part, based on the sequence of events leading up to the encounter. When two or more competing manners of death appear viable and the evidence at hand offers no clear choice between them, the manner is classified as Undetermined.

Recommendations:

To the Ontario Police College:

1. **We recommend that the Ontario Police College include training by consumers/survivors of mental health services when providing EDP (Emotionally Disturbed Persons) training.**

Coroner's comment:
The inquest heard testimony from a representative of the Empowerment Council, a special interest group advocating for current and former psychiatric patients. The experience from a nearby, major urban centre seems to support the benefits of police training that includes input from mental health service consumer/survivors who have had encounters with the police, and who can provide some insight and understanding from their perspective. A more 'holistic' approach to police training may aid in the decision-making process during stressful, critical encounters.

2. **We suggest that the events surrounding Mr. Mesic's death be included in scenario training at the Ontario Police College.**

Coroner's comment:
The circumstances of Mr. Mesic's death were complex, challenging and rapidly evolving. The jury felt that it would afford both new and experienced police officers a complex, fact-based case scenario that would be of benefit to experience and review to further enhance the OPC curriculum.

To the Hamilton Police Service:

3. **We recommend that the Hamilton Police Service receive additional EDP training (annually) by consumers/survivors of mental health services, due to the statistics supporting the amount of police calls dealing with EDP within Hamilton.**

Coroner's comment:
The jury heard that a significant and disproportionate number of police calls involve emotionally disturbed individuals. While few of these encounters develop into a physical confrontation, and even fewer result in death, the jury is suggesting that training would benefit from the perspective of those who have experienced interactions with police while they were in an emotional crisis. A more balanced approach to training might assist police officers in dealing with these encounters and support critical decision-making.

4. **We recommend that Hamilton Police Service consider the feasibility of radio prompts in addition to MDT messages to alert officers of persons displaying self-harm and harm to others.**

Coroner's comment:
The jury heard that the current system of messaging via Mobile Data Terminals (MDT) may result in messages being missed or not read for some period of time. The addition of radio prompts for select messages may aid in drawing the attention of police officers to critical information and events in a more timely fashion.

5. **We recommend that the Hamilton Police Service study the results of the current project piloted by Toronto Police Services with respect to lapel cameras. If the results warrant, then we recommend the program be introduced to Hamilton Police Service.**

Coroner's comment:
The jury heard testimony regarding the potential benefits of lapel-mounted cameras to capture the events of critical incidents, but the jury also heard about the limitations of and concerns with these cameras. The jury has taken a cautious approach in recommending that any local decisions be made prudently and be evidence-based.

To All Police Services within Ontario:

6. **We recommend that all Police Services in Ontario provide Subject Officers mandatory "Re-Certification" of "use of force" training and mandatory consultations with psychologists prior to returning to work after lethal use of force scenarios.**

Coroner's comment:
The jury heard that all officers must be re-certified in use-of-force on an annual basis. Officers involved in a fatal incident are not required to demonstrate proficiency in the application of use-of-force techniques, nor are they screened psychologically before returning to active duty. The inquest heard that officers may be psychologically impacted by the events such that their judgment may be compromised. The concern is that they may be too quick to apply lethal use-of-force or, alternatively, reluctant to apply lethal use-of-force due to their past experiences. Both scenarios present potential risks to public and/or officer safety. The jury is suggesting that more thorough evaluation of the officer's skill-set and emotional state should occur before returning an officer to active duty following a lethal use-of-force scenario.

To St. Joseph's Healthcare Hamilton (the Hospital):
<Note that "client" and "patient" are used interchangeably in this recommendation.>

7. **We recommend that St. Joseph's Hospital review its client observation process, and monitor staff adherence to this process including the use of electronic documentation device (Tough book), in the Mental Health and Addiction Program. We suggest that the hospital consider enhanced identification measures such as the possibility of using an arm band bar-code scanning system or including patient photos in client profiles to facilitate accurate observations, increase meaningful interactions between staff and clients and provide precise documentation of client location.**

Coroner's comment:
The inquest heard that an electronic documentation device indicated that Mr. Mesic was recorded as having been 'observed' by the nursing staff to be on the medical floor for several hours after he was known to have died outside his residence. This raised concerns about the reliability of patient observations on the psychiatric ward. Testimony suggested that the operation of the electronic equipment may not be optimal and that other measures for patient identification could be of

assistance. Finally, the inquest heard that more personal interactions between the staff and patients might be of therapeutic benefit, in addition to providing better security.

8. **We recommend that St. Joseph's Hospital develop a specific policy for the Mental Health and Addiction Program in order to provide direction to staff in the management of "Off Ward Passes" and for voluntary clients who do not return, and that this program be reviewed by staff and doctors annually.**

Coroner's comment:
There appeared to be some confusion and inconsistency in practice from the health care personnel, both the doctors and nurses, as to how to manage the scenario whereby a voluntary patient has left the ward on a pass and has apparently not returned. Although likely not material in this death scenario, the jury is suggesting a benefit to clarifying the policy in this regard.

9. **We recommend that St. Joseph's Hospital standardize the transfer of primary responsibility between physicians and that this information be included as part of the permanent client record.**

Coroner's comment:
Mr. Mesic's care was transferred from one attending psychiatrist to another during the course of his admission with little documentation as to how this transfer of care was arranged, what information was shared and what the treatment plan was. It is difficult to ascertain whether or not the transfer of care was material in any way to the death, but the jury is suggesting a benefit from standardizing this procedure as well.

10. **We recommend that where family involvement is accepted by the client, that St. Joseph's Mental Health and Addiction Program increase communication with the family as to the plan of care prior to the expiration or change of a "Form 1" and/or "Form 3".**

Coroner's comment:
The jury recognized the need for patient consent when involving the patient's family in the care plan and the jury also recognized that family involvement may not always be appropriate. The inquest heard, however, of the potential benefits to both patient and family of including the family as active participants in the care plan early on in the process. The jury felt that a more careful reintegration of psychiatric patients into the community might aid in preventing a similar situation from developing in the future.

Closing Comment:

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I have made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.

Jack R. Stanborough MD
Presiding Coroner
Office of the Chief Coroner
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August 25, 2014