February 1, 2015
Ministry of Community Safety
and Correctional Services
18th Floor
25 Grosvenor Street
Toronto, On M7A 1Y6

To whom it may concern:

Re: complaint against Dr Dirk Huyer - chief coroner
File: 2012-7219

I am writing to you to complain about Dr. Huyer's decision not to grant an inquest into my son's death June 12/12. See attached fils "letter to Dr Huyer" and Coroner decision" .

I feel Dr. Huyer has violated the coroner's act as per the following facts:

He claims it is not an issue of public safety and the public would not benefit from an inquest. If my son's death does not speak to public safety I do not know what does.

1. Joshua was medically cleared on June 6/12 by Dr N even though he clearly was not medically clear as the blood work speaks for itself. Dr N did not even consult with Poison Control who are the experts. As a result of medically clearing Josh, Dr N put Joshua in great danger and I believe this set off the chain of events that led to his premature death.

2. Doctor G now accepted Joshua to the mental health floor knowing about Josh's rising ammonia levels and the fact that the Mental Health Unit is not equipped to deal with this.

3. Poison control told them not to give Joshua Haldol and both Dr. G and the following internist, Dr. S both prescribed this. This tells me how negligent they both were as they did not even read the previous records. Even though the pharmacy records for the Haldol on June 6 seem to be missing, I firmly believe they administered this. Regardless, just the prescribing of this is speaking to patient safety.

4. Dr. S clearly violated the "Consent to treatment act" by not notifying me as next of kin when Joshua became incoherent at approximately 7:30 pm. I was not notified until after midnight. I believe if I had been notified I could have gone to the hospital and helped them as Joshua trusted me and would listen to me. I believe the people closest to the patient know them better than anyone else and should be involved with something as serious as what was happening to my son. In the end it became an emergency and they had to restrain him but they had over 4 hours previously to contact me and never did. I was never consulted on his treatment and my permission was never obtained.

5. Dr. S clearly violated the "Minimal restraints act" by keeping my son physically and chemically restrained for over 4 days. Dr. Huyer states that Joshua was intermittently physically restrained and this is not true. I have witness statements to this from everyone who visited with him in the ICU. I was with Joshua almost 24/7 during this time and he had four restraints on him for the first couple of days and the wrist restraints were on him the whole time until they extubated him. The only reason given for keeping him restrained both chemically and physically was that he got a "little agitated" when they tried to wean him. This is a natural reaction by anyone and certainly not good enough reason to keep someone dangerously restrained like this for so long. There was no medical reason for it. Consequently he developed a blood clot which eventually led to his death. I am certain that the fact he was restrained for so long caused this as it is a well known fact that immobility is a cause of blood clots developing. See attached files "witness statements".

6. An hour after he was extubated he had a code blue and this was not investigated. They just chalked it up to being dizzy. This is safe practice?

7. He was prematurely discharged from the ICU because they needed the bed. He had a high heart rate, fever, stomach cramps and was paranoid at the time. He clearly was unstable when they sent him to the medical floor as per the records. At the very least he should have had one to one nursing care. The nurse who received him, apparently was arguing with ICU about this before they released him but they did not listen.

8. Dr. S diagnosed Joshua from the beginning of his arrival in ICU with aspirated pneumonia even though five consecutive x-rays showed his lungs to be "grossly clear". When a doctor is proven wrong about a diagnosis they should look for other causes of the patient's symptoms. It was the blood clot causing these symptoms. This is safe?

9. I believe the coroner's act states that if a patient is being kept against their will there is supposed to be a mandatory inquest. Given the fact that he was kept restrained for over 4 days and he died from a pulmonary embolism I believe an inquest should be granted. Also Dr Huyer totally ignored the fact that in the records it states that "patient is being compliant at present but will be formed if he tries to leave." This clearly shows that although Joshua did not know it, he was being kept against his will and he would have been sent back to the "Mental Health Unit" if he had been medically cleared again. They had no intentions of letting him leave before mental health treatment.

I have complained to the CPSO and also have appealed their decisions with HPARB. I am currently awaiting HPARB's decision. See attached files "HPARB APPEAL".

I am well aware that blame can not be assigned by an inquest and this is not important to me as I know full well who is to blame. This is about patient safety. Dr Huyer states that somehow this could not help in the future of patient safety for the public. Many people all over this province are brought to hospitals after attempting suicide and if the proper protocols are ignored this is

certainly dangerous to the patient. I feel an inquest would most definitely help in the future care of patients.

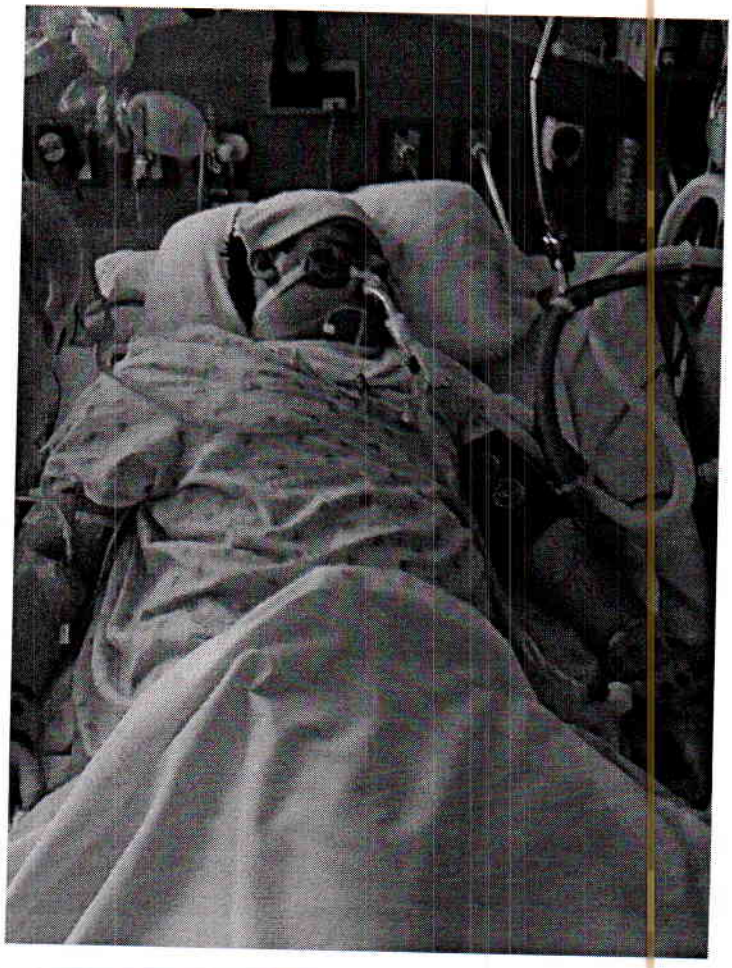
There can be no doubt that Dr Huyer is trying to protect the doctors involved and not protect the public. This is not "Speaking for the dead to protect the public". This is just a coverup on his part and an obvious abuse of his power as Chief Coroner.

Lastly I complained that the coroner states the cause of Joshua's death to be suicide. This is nonsense. He was hospitalized for almost 8 days and the medications he took were long gone out of his system. He died by pulmonary embolism and should be listed at the very least as natural causes. This has never been addressed. Of course it is easy to blame the patient. Although Joshua was responsible for taking the overdose, he was not responsible for the very unsafe and negligent care he received after being admitted.

I would like to believe there are still some people in our government who have integrity and still hold public safety in the highest regard.

Sincerely,

Mary-Lou Patey
mother and next of kin to
Joshua Alvin Patey DOB Nov 4, 1986 Deceased June 12, 2012



attachments: zipped files 2015-02-01

1. letter to dr huyer
2. coroner's decision
3. hparbappeal
4. witness statements

Ministry of Community Safety and Correctional Services

Office of the Deputy Minister
Community Safety

25 Grosvenor Street
11th Floor
Toronto ON M7A 1Y6
Tel: 416-326-5060
Fax: 416-327-0469

Ministère de la Sécurité communautaire et des Services correctionnels

Bureau du sous-ministre
Sécurité communautaire

25, rue Grosvenor
11e étage
Toronto ON M7A 1Y6
Tél. : 416-326-5060
Téléc. : 416-327-0469

Ontario

MC-2015-457

MAR 17 2015

Ms. Mary-Lou Patey

Dear Ms. Patey:

Thank you for your e-mail of February 3, 2015, and the attached correspondence dated February 1, 2015, regarding the Office of the Chief Coroner for Ontario.

Please accept my sincere condolences on the loss of your son.

As you have correctly noted, a complaint about a coroner's decision not to hold an inquest is not a complaint that can be dealt with by the Death Investigation Oversight Council.

I would further note that, pursuant to subsection 26(3) of the *Coroners Act*, a decision made by the Chief Coroner in response to a relative's request to hold an inquest, is a final one. As such, I have no authority to review or change Dr. Huyer's decision to not hold an inquest into the death of your son.

Sincerely,

Matthew Torigian
Deputy Minister of Community Safety

Feb 15/16
ATT: Commissioner J.V.N. (Vince) Hawkes
General Headquarters
Lincoln M. Alexander Building
777 Memorial Avenue
Orillia, ON L3V 7V3 (705) 329-6111 1-888-310-1122

Re: Complaint against the following coroners.
Dr. Jack Stanborough - Regional Supervising Coroner
West Region Hamilton Office

Dr. William Lucas - Deputy Chief Coroner
Office of the Chief Coroner

Dr. Dirk Huyer - Chief Coroner Ontario

Dear Commissioner Hawkes:

I am writing to you to ask that you investigate the above mentioned coroners for "Breach of Trust". My son died on June 12/12 from a pulmonary embolism (blood clot to the lung) which was most certainly caused by being restrained for over 4 days at Cambridge Memorial Hospital. Besides the many mistakes including violations of other Ontario Acts made during his care I believe all three coroner's have violated the Coroner's Act.

> Death while restrained on premises of psychiatric facility, etc.
> (4.7) Where a person dies while being restrained and while detained in and on the premises of a psychiatric facility within the meaning of the Mental Health Act or a hospital within the meaning of Part XX.1 (Mental Disorder) of the Criminal Code (Canada), the officer in charge of the psychiatric facility or the person in charge of the hospital, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body. 2009, c. 15, s. 6 (4).

After being restrained both chemically and physically for over four days in ICU my son suffered a code blue just one hour after being extubated. Although he was revived at this time, the doctors failed to investigate this and chalked it up to being dizzy from the medications he received. According to the autopsy report the coroner, Dr. Stanborough, felt it was probably an indication of a blood clot.

He was kept in the ICU for the next day with very limited movement. The next day they cleared him and transferred him to the 5th floor where approximately ½ hour later he would suffer another code blue and die from this. I believe it is obvious that by being transferred the physical movement involved would start the blood clot to travel through his system.

At the time of his death he was being held under the "Mental Health Act' meaning he would have been transferred to the Mental Health Unit if he had recovered. I am enclosing records of this with this letter.

I requested an inquest from all three of the coroners mentioned but was refused by all. They claim it has nothing to do with public safety but there are many public safety issues regarding his treatment which I would be glad to discuss with you. Because of the circumstances of his death by a blood clot and being held under the Mental Health Act a "MANDATORY INQUEST" should have been ordered immediately. I should not have had to request this. This is the law.

The first coroner, Dr. Stanborough, believes that because he sent the case to the "Patient Safety Review Committee" that this is all that he needed to do. Many protocols were broken during my son's care which I feel contributed greatly to his death and speak volumes to public safety.

Also I would like to note that the office of the chief coroner went through many staff changes and my son's case was passed on to different coroners.

The fact remains that a "Mandatory Inquest" should have been ordered as per the Coroners Act and this was totally ignored by all of the coroners involved.

I would be very much like to meet with you to discuss this further and present you with all correspondence between the coroners and myself.

sincerely,

Mary-Lou Patey - mother and next of kin to
Joshua Alvin Patey DOB - Nov 4, 1986 Deceased June 12, 2012

enclosures

RUN DATE: 12/06/12
RUN TIME: 1452
RUN USER: PCNSRNPXC

Cambridge Memorial ** Patient Care **
PATIENT ASSESSMENT

PAGE 1

Transfer Accountability Report

Patient: PATEY, JOSHUA ALVIN
Account #: AC001671/12
Admit Date: 06/06/12
Status: ADM IN
Attending: S

Age/Sex: 25 M
Unit #: 016955
Location: 2ICU
Room/Bed: ICU-5

Age: 25 Admitting Diagnosis: MIXED O.D

MRP/Attending: S

Code Status: FULL

Past Medical History
: BIPOLAR/PARANOID
:

Isolation/Precautions: N/A

Press F5 to recall Allergy information & review before FILE.

:* Drug Allergy/Reaction:
NONE KNOWN

:* Food Allergy:
NONE

:* Non Food/Drug Allergies:
NONE KNOWN

:* *Other* Food Allergy:

- Airway/Breathing Assessment -

Resp. Rate: 24 FiO2: RA O2 Delivery: SaO2(%): 90

Trach? Home CPAP? Chest Tube?

Comments:

- Circulation -

Pulse/HR: 130 Lt. Cuff BP: 123/79 Rt. Cuff BP: 132/70 Rhythm: ST

Comments: PT FEBRILE

IV Therapy: SALINE LOCK RIGHT UPPER ARM

Pain Scale: at rest: 0 PCA? Epidural?
with movement:

Comments:

Mental Status: Confused

* pt not a form but mental health says call mental health or if pt wants to leave and they will form him *

CAMBRIDGE MEMORIAL HOSPITAL
700 CORONATION BLVD.,
CAMBRIDGE, ONTARIO N1R 3G2
TELEPHONE: 519-621-2330

CONSULTATION REPORT

AUG 0 8 2012

DATE TRANSCRIBED: 13/06/12
DATE DICTATED: 12/06/12
PATIENT'S NAME: PATEY,JOSHUA ALVIN
PATIENT'S U#: 016955
PATIENT'S Acct#: AC001671/12
REGISTRATION DATE: 06/06/12
PATIENT'S DOB: 04/11/86
PATIENT'S LOC: 5MED
HEALTH CARD:

Current Report by: D

COPY FOR :

COPIES: A

Mr. Joshua Patey was seen by Dr. D today. I interviewed both him and interviewed with his mother to try and sort out his new onset agitation, paranoia. He does have a history of bipolar depression followed by Dr. I and does have a history of extensive alcohol use to try and cope with them. Apparently he works at the C C and does writing but feels inadequate and often has to drink. He does have a history of bipolarity with a being treated by Dr.

At this point he overdosed six days ago, on Effexor, Nozinan and Abilify because he felt the state of the world was so negative and now he has went into a serotonergic agitated state and had to be intubated. He is back down in ICU and struggling somewhat with chest congestion. When the intubation was removed he became paranoid, thought people were trying to kill him and hurt him. He has been seeing things in his room. Certainly while talking to him his pulse was 131. He is feeling very frightened. He does have some insight and he was oriented to person, place and time but to settle him down and treat this level paranoia we are going to add in Zyprexa 5 mg twice a day and Clonazepam 0.5 twice a day. I am going to try a bit of 1 mg Lorazepam just to see if I can calm him down.

He is an organic brain syndrome, his delirium is probably multifactorial with the infection, anticholinergic affect of the medications and there is possibly an underlying non treated bipolarity causing some of his agitated state. Because he says without medications he can get angry, has a history of bar fights and being aggressive on the football field.

He says this year while on the Effexor and Abilify he was having a lot of agitated periods at times for which he was drinking and quite possibly he was self medicating the bipolarity and I am not sure if he was taking Zyprexa or not. He is interested in perhaps going on Zeldox which his relative has done well on but this will all be decided once we are able to move him to the psych ward til we get him medically stabilized.

518

Physician: D
Copy for:

PATEY, JOSHUA ALVIN
016955

AUG 0 8 2012

I am going to continue on with a Form 1. He is staying in hospital right now voluntarily which is good but with his changeable insight if he does try to leave hospital we will have to certify him and continue to treat him because certainly he is not biochemically stable at this point and he will likely require a transfer to the inpatient unit to fully stabilize him psychiatrically with the correct medication ongoing and connect him for some resources to manage his alcohol dependency.

D M.D. BSCH., F.R.C.P. (C)

Transcribed by: BRENDA/MedRec MARTIN

519

** End of Report **

CAMBRIDGE MEMORIAL PCI **LIVE** (PCI: OR Database CMO)

DRAFT COPY

Run: 30/07/12-07:55 by BUI, HAI ANH (ANN)

Ontario Provincial Police
Police provinciale de l'Ontario

Corporate Communications and Strategy Management Bureau
Bureau des communications et de la gestion des stratégies

777 Memorial Ave.
Orillia ON L3V 7V3

777, avenue Memorial
Orillia ON L3V 7V3

Tel: 705 329-6860
Fax: 705 329-6244

Tél. : 705 329-6860
Téléc.: 705 329-6244

File Reference: OPP-7720

March 11, 2016

Ms. Mary-Lou Patey

Dear Ms. Patey:

Thank you for your letter, addressed to Ontario Provincial Police (OPP) Commissioner J.V.N. (Vince) Hawkes, requesting the OPP investigate your allegations against the coroners who were involved in your son's case following his death. As Manager of OPP Corporate Communications, Corporate Communications and Strategy Management Bureau, I am responsible for responding to general inquiries received from members of the public and am pleased to reply.

May I extend my deepest condolences on the loss of Joshua.

Please be advised that the concerns you raise are not matters for the OPP to address. You may, therefore, wish to forward your comments to the Death Investigation Oversight Council (DIOC), the oversight body for the Office of the Chief Coroner and the Ontario Forensic Pathology Service. The DIOC is an independent advisory agency that oversees coroners and forensic pathologists in Ontario, and can be reached at 15th Floor, 25 Grosvenor Street, Toronto, Ontario, M7A 1Y9, or via email at dioc@ontario.ca.

I appreciate the opportunity to respond to your correspondence.

Yours truly,

Bradley McCallum
Inspector
Manager, Corporate Communications
Corporate Communications and
Strategy Management Bureau

/jtm

March 25/16

Hon Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Dr. Hoskins:

I recently sent the enclosed letter to the Ontario Provincial Police Commissioner. I am enclosing my letter as well as the response I received .

I am very disappointed in the response since the Death Investigation Oversight Council has no power over the inquest decision made by a coroner. Also, given the fact that Dr. Dirk Huyer is a member of the board, an appeal to them regarding this would be a "conflict of interest."

It seems to me that the coroners can just decide whatever they please and go against the "Coroner's Act of Ontario" at will.

I am requesting that you investigate this matter or advise me as to whom has the power to do so. This is clearly a "Breach of Trust" on the part of all coroners concerned.

Sincerely,

Mary-Lou Patey

Mary-Lou Patey
mother and next of kin to
Joshua Alvin Patey DOB - Nov 4, 1986 deceased June 12, 2012

copy - Hon Madeleine Meilleur
Ministry of the Attorney General
McMurtry-Scott Building
720 Bay Street, 11th Floor
Toronto, ON
M7A 2S9

Ontario
Death Investigation Oversight Council

Complaints

In addition to its general oversight role, DIOC administers a public complaints process through its Complaints Committee.

The Committee reviews complaints regarding death investigations and, if required, provides recommendations to either the Chief Coroner or Chief Forensic Pathologist (or both) with a goal of improving Ontario's death investigation system.

General Questions Regarding Complaint Files	
Q: Who can file a complaint?	**A:** Any person may make a complaint to the complaints committee about a coroner, a pathologist or a person, other than a coroner or pathologist, with powers or duties under the Coroners Act.
Q: What types of complaints does the Complaints Committee have the authority to review?	**A:** The Complaints Committee is responsible for reviewing complaints regarding a coroner, pathologist or certain other persons referred to under the Coroners Act who have powers or duties for post-mortem examinations. In addition, the Committee reviews complaints directly about the Chief Coroner or Chief Forensic Pathologist.
Q: What types of complaints are out of scope and are not reviewed by the Complaints Committee?	**A:** Please note that DIOC's Complaints Committee has no authority to review the following types of complaints: Complaints about a coroner's decision regarding: • whether to hold an inquest, • the scheduling of an inquest, • the conduct of an inquest, or • any decisions made during an inquest. These matters are under the legislative authority of a coroner under the Coroners Act and the Chief Coroner has the sole authority under the legislation to make a final determination on such matters. • Complaints that do not relate to a power or duty of a coroner or pathologist. • Complaints that are trivial, vexatious or not made in good faith.
Q: How can I file a complaint?	**A:** Complaints can be filed in writing (by emailing dioc@ontario.ca) or by telephone (by calling 416-212-8443 or our toll free number 1-855-240-3414). Arrangements to submit your supporting documentation should be made directly with the DIOC Secretariat, but usually involve submission by mail or email. Addresses to forward necessary documentation to: **Email:** dioc@ontario.ca **Address:** 25 Grosvenor St. 15th Floor

Ministry of Health
and Long-Term Care

Correspondence Services
M1-55, Macdonald Block
900 Bay Street
Toronto ON M7A 1R3

Ministère de la Santé
et des Soins de longue durée

Services de correspondance
M1-55, édifice Macdonald
900, rue Bay
Toronto ON M7A 1R3

Ontario

HLTC2966MC-2016-3457

APR 0 6 2016

Ms. Mary-Lou Patey

Dear Ms. Patey:

Thank you for your letter dated March 25, 2016, to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, regarding your allegations against the coroners following your son's death. Your letter has been reviewed by ministry staff who provided the following information.

The ministry wishes to extend its condolences on your loss.

Unfortunately, the ministry has no jurisdiction to comment on the concerns you have raised. If you wish, your inquiry would be better addressed by the ministry's colleagues at the Ministry of Community Safety and Correctional Services at:

Ministry of Community Safety and Correctional Services
Communications Branch
25 Grosvenor Street, 10th Floor
Toronto ON M7A 1Y6
Tel: 416-326-5000
Toll Free: 866-517-0571

Again, thank you for the opportunity to respond to your concerns.

Sincerely,

J. King
Correspondence Services
Ministry of Health and Long-Term Care

April 28/16

Hon Yasir Naqvi
Ministry of Community Safety and Correctional Services
Communications Branch
25 Grosvenor Street, 10th floor
Toronto, On M7A 1Y6

Dear sir:

Is there anyone in our government who is not afraid to investigate the coroners for "|Breach of Trust"? It would seem that all parties I have contacted have "passed the buck".

Are our coroners in this province "|Above the Law" or are the laws just there to placate us into thinking we are protected.

I am very frustrated with the "run around" I have received thus far.

As a tax paying Canadian citizen I believe that I should have the same rights as the coroners do.

I am forwarding my correspondence with the various ministries I have contacted so far.

Please advise me as to whom has the proper authority to investigate coroners' decisions or are they not bound by any laws.

Does this mean that the only alternative I have is by going before a Justice of the Peace to press criminal charges on my own?

Awaiting you response,

Mary-Lou Patey
mother and next of kin to
Joshua |Alvin Patey
DOB Nov 4/86 - deceased June 12/12

Ministry of Community Safety and Correctional Services

Office of the Deputy Minister

25 Grosvenor Street
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Ministère de la Sécurité communautaire et des Services correctionnels

Bureau du sous-ministre

25, rue Grosvenor
11e étage
Toronto ON M7A 1Y6
Tél. : 416-326-5060
Téléc. : 416-327-0469

Ontario

MC-2016-1613

MAY 25 2016

Ms. Mary-Lou Patey

Dear Ms. Patey:

Thank you for your letter of April 28, 2016, addressed to the Honourable Yasir Naqvi, Minister of Community Safety and Correctional Services, regarding the oversight of coroners. I am responding on behalf of Minister Naqvi.

From previous correspondence, I know that you are aware that when a coroner determines that an inquest is not necessary, section 26 of the *Coroners Act* enables a family member of the deceased to make a written request to the coroner that an inquest be held. Section 26 further enables the family member to ask the Chief Coroner to review that coroner's decision, if the decision was not to hold an inquest.

Once a decision has been made by the Chief Coroner under section 26, it is final. There is no further recourse under the *Coroners Act* to open a review of the Chief Coroner's decision not to hold an inquest. As you are also aware, the *Coroners Act* establishes the Death Investigation Oversight Council and it requires there be a complaints committee. Among other things, the committee deals with complaints about coroners. However, a coroner's decision to hold an inquest, or not to hold an inquest, is expressly excluded from the jurisdiction of the complaints committee.

If your concern relates to the decision that an inquest into the death of your son not be held, you may wish to consult a lawyer to determine whether there are options for you to consider outside the context of the *Coroners Act*. However, please note that the ministry cannot provide legal advice in that regard.

Sincerely,

Matthew Torigian
Deputy Minister
Ministry of Community Safety and Correctional Services

c: The Honourable Yasir Naqvi
Minister of Community Safety and Correctional Services