Jeffrey James – Death by "Restraint"

by Don Weitz

For two or three days, I attended the recent inquest in the tragic death of Jeffrey James, it ended in Toronto on October 10, 2008. Although there were some good and detailed recommendations from the Empowerment Council and Coroner's Jury, the Jury did not demand the end of physical restraints (e.g. 2-point & 4-point restraints) and "seclusion" (solitary confinement, but the Council did. The Jury should have at least recommended phasing out all physical restraints and seclusion because they're forms of cruel and unusual punishment or torture.

The fact is that physical restraints triggered the "pulmonary thromboembolism" (blot clot in lungs that traveled from James' leg) that killed Jeffrey James. A young 34-year old black man, Jeffrey died a horrible death in the Centre for Addiction and Mental Health (CAMH), Toronto's notorious psychoprison, on July 13, 2005. Approximately one month before he died, James had been transferred from Oak Ridge/Penetanguishene Mental Health Centre, another Ontario psychoprison notorious for its brutality; he ended up CAMH's "medium-security" Unit (3-2) - but not for long. For 5 1/2 consecutive days, Jeffrey was severely restrained - tied down with 4-point restraints wrapped around his ankles and wrists, forced to lie on his back so he couldn't move his arms and legs, forbidden to get up and exercise, "chemically restrained" (forcibly drugged) with the powerful neuroleptic Loxepine and 'minor tranquillizer' Lorazepam - while languishing in solitary confinement ("seclusion")! CAMH psychiatrists and doctors repeatedly ordered physical restraints ad seclusion; in fact, they didn't even examine Jeffrey before writing restraint orders - facts confirmed during the cross-examination of Drs. Siu and Darby by lawyer Anita Szigeti. Psychiatrist Siu was the last doctor to see Jeffrey, he wrote restraint orders one and two days before Jeffrey died. According to Szigeti, who represented the Empowerment Council at the inquest, Dr. Siu also failed to request an "external consult" (a second opinion) after 72 hours of continuous physical restraint. This sounds unethical to me-- a violation of hospital or provincial government restraint guidelines, medical neglect, or a breach of medical ethics.

It's bizarre as to how James ended up in physical restraints and "seclusion" in the first place. The psychiatrists threw James into "seclusion" after some nurses complained to a psychiatrist that James was "masturbating" in front of the nursing station - horrors at such "inappropriate sexual behaviour"! Although he was previously accused of "sexual assault", James had not assaulted or harmed any CAMH staff or patient. It's also important to point out that no nurse and no psychiatrist or doctor bothered to communicate with and <u>understand James as a person</u> before he died. Apparently, dialogue (not to mention empathy or compassion) is a 'privilege' at CAMH and other Ontario psychoprisons.

2-point and 4-point physical restraints and "seclusion" in psychiatric facilities constitute cruel and unusual punishment or torture sanitized as "restraint". I may report these psychiatric tortures to Amnesty International and the United Nations Committee Against Torture; owever, I'm not hopeful of action since neither human rights body has officially condemned physical restraints, forced drugging or electroshock ("ECT") as forms of torture. So far, no doctor or psychiatrist is being held accountable for Jeffrey James' death – unfortunately the Coroner's Act of Ontario forbids the corner or coroner's jury from blaming or charging anybody with unethical conduct or a crime. Let's get real here. Like coroners, most judges uncritically accept or believe that psychiatry's fraudulent medical model is "medical science"; coroners and judges rarely challenge psychiatric "expertise", they rarely question bogus psychiatric procedures including forced drugging, electroshock, physical restraints or "seclusion" (solitary confinement).

Nevertheless, some of the jury's 66 recommendations were constructive and helpful- if acted on. For many years, the Ontario government has been notoriously and routinely negligent in refusing to enforce jury recommendations, especially those concerning psychiatric survivors and homeless people. One recommendation in the James inquest states that the Chief Coroner of Ontario must call an inquest when anybody dies while in physical restraints, but why limit the call to only physical restraints? Many more psychiatric prisoners (involuntary psychiatric patients) also die from chemical restraints (forced drugging), some from electroshock ('ECT'). Obviously, this recommendation doesn't go far enough. When a person dies in an Ontario jail or prison (by whatever means), the Coroner must call an inquest, but the Coroner doesn't have to call an inquest if a person dies in a psychiatric facility or "mental health centre"; according to the Coroner's Act, that decision is "discretionary". In a recent human rights case, the Ontario Human Rights Tribunal justly and wisely ruled that inquests into deaths in psychiatric facilities should be mandatory- just as they are for prisons, but an Ontario Superior Court judge recently overruled this important Tribunal decision.(1)

In the meantime, physical restraints, seclusion, trauma, deaths and cover-ups continue at CAMH and every other psychoprison in Ontario and other provinces. Unfortunately, psychiatric torture is not and never was an election issue - it should be. Another national and international shame!

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