Verdict of Coroner’s Jury
Office of the Chief Coroner

The Coroners Act – Province of Ontario

Surname: Go
Given names: Gerald
Aged: 53

Held at: 25 Morton Shulman Ave, Toronto
From the: 24th day of March
To the: 27th day of March
By: Dr. David Eden, Coroner for Ontario
having been duly sworn/affirmed, have inquired into and determined the following:

Name of Deceased: Gerald Go
Date and Time of Death: May 14th, 2010, 00:00 hours
Place of Death: In ambulance en route to Scarborough General Hospital
Cause of Death: Combined toxicity of Quetiapine, Doxepin and Amitriptyline
By what means: Suicide

This verdict was received on the 27th day of March, 2014
Coroner’s Name: Dr. David Eden
(original signed by Coroner)

We, the jury, wish to make the following recommendations:

Inquest into the death of:

Gerald Go
Jury Recommendations

To the Ministry of Community Safety and Correctional Services:

1. That the Ministry should, where feasible and lawful, facilitate awareness by jail staff of any events outside and within the facility which may increase the risk of suicide in an inmate, and initiate appropriate actions to offer assistance to the inmate in coping with the event, and to prevent suicide.

2. We encourage the Ministry to continue to monitor and take appropriate measures to identify and reduce “cheeking”, hoarding and diversion of drugs by inmates.

3. That every effort should be made to administer medication when the inmates are not in lockdown. If lockdown is unavoidable, medication should be administered in a fashion that would maximize visibility between the inmate and the administering nurse. (During Lockdown each inmate should be administered medication outside of the cell so that he may be clearly observed by staff.)

4. When medication administered on the range, inmates should be instructed to stand in line and to stand well back from the grill door until it is their turn to see the nurse. (On the range, inmates should be administered medication in an orderly fashion.)

5. That the Ministry should put more consistent practices into place to ensure that the emergency cart is properly prepared and personnel to deal with medical emergencies are adequate.

6. That the Ministry review its Medication Dispensing System at the Toronto East Detention Centre, taking into account systems used in other settings and practices recommended by the Institute for Safe Medication Practices Canada with the view and ultimate goals of:

   a. Improving medication practices in existence at the Toronto East Detention Centre;
   b. Ensuring that the 5 Rights of Medication Dispensing (right patient, right medication, right time, right dose and right route) are achieves;
   c. Improving record keeping practices.

7. That the Ministry work towards reducing initial response time to inmates in crisis at the Toronto East Detention Centre.