2024 CarswellOnt 6437
Ontario Coroner

Romanick, Re

2024 CarswellOnt 6437

Inquest into the Death of Chad William ROMANICK

Selwyn A. Pieters Presiding Officer

Heard: March 25, 2024; March 26, 2024; March 27, 2024; March 28, 2024; March 29, 2024; March 30, 2024; March 31, 2024; April 1, 2024; April 2, 2024; April 3, 2024; April 4, 2024
Judgment: April 23, 2024
Docket: None given.

Proceedings: additional reasons to *Romanick, Re* (2024), 2024 CarswellOnt 5201, Selwyn Pieters Presiding Officer (Ont. Coroner)

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Bryce Chandler, for Windsor Police Service Chief and Windsor Police Service Board, Sergeant John MacDougall, Sergeant James Hladki
Aislinn Reid, Lipi Mishra, for Windsor Regional Hospital
Shannon Tompkins, for Hotel Dieu Grace Healthcare

Subject: Civil Practice and Procedure
Related Abridgment Classifications
Judges and courts
VII Coroners
VII.2 Coroner's inquest
VII.2.b Practice and procedure
VII.2.b.ix Verdict or inquisition
VII.2.b.ix.B Explanation of verdict
Headnote
Judges and courts --- Coroners — Coroner's inquest — Practice and procedure — Verdict or inquisition — Explanation of verdict
Explanation of verdict following inquest into death.
Table of Authorities
Statutes considered:
Coroners Act, R.S.O. 1990, c. C.37
s. 10

s. 31(1)
Mental Health Act, R.S.O. 1990, c. M.7
s. 17

***Selwyn A. Pieters Presiding Officer*:**

OPENING COMMENT

1 This verdict explanation is intended to give the reader a brief overview of the circumstances surrounding the death of Chad William Romanick along with some context for the verdict reached by the jury. The synopsis of events and comments are based on the evidence presented orally and in writing to assist in understanding the jury's basis for its recommendations.

PARTICIPANTS

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SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

3 This inquest concerns the death of Chad William Romanick, 34 years old, who died on September 15, 2017, at his residence in Windsor, Ontario.

4 On September 15, 2017, members of the Amherstburg Police Service (APS), Windsor Police Service Emergency Services Unit (WPSESU), and the Repeat Offender Parole Enforcement Unit (ROPE) had set up a perimeter around Mr. Romanick residence and were attempting to safely arrest him for an attempted murder. The police had reasonable grounds to believe that Mr. Romanick was responsible for shooting a male with a shot gun in Amherstburg at approximately 2:30 earlier that morning.

5 As part of their planning and preparation, the police obtained information about Mr. Romanick's history from background checks they conducted through Windsor Police records management system, CPIC, and other databases, in addition to social media. None of the information the police obtained on the morning of September 15 th revealed that just three days earlier on September 12 th , members of the WPS service attended Mr. Romanick's residence twice as a result of two separate 911 calls that he made. The second police attendance was coded as a Person in Crisis (PIC) and resulted in Mr. Romanick being transported to the Emergency Department of the Windsor Regional Hospital (WRH) by ambulance, followed by a WPS officer. Details from that call included reference to Mr. Romanick having a plan to commit suicide the previous day.

6 As the investigation and containment planning progressed on the morning of September 15, 2017, police were confident that Mr. Romanick was somewhere inside the residence because his vehicle — earlier identified as the suspect vehicle — was in the driveway, and information obtained from a cellular phone provider confirmed that Mr. Romanick's cell phone was near his residence.

7 At about 10:27 a.m., the perimeter around Mr. Romanick's residence was contained and the ESU team leader began utilizing numerous methods to contact Mr. Romanick. These methods included calling his cell phone and leaving a message, sending a text message to his cell phone, speaking through a bull horn, and using the wail and horn from a police vehicle. Mr. Romanick did not provide the police with any type of response until 1:00 p.m. when officers, who were positioned to the rear of residence, heard a muffled gunshot from the detached garage. The ESU team leader was speaking on the phone with Mr. Romanick's father when this occurred.

8 Mr. Romanick's father provided information about mental health and addiction challenges that Mr. Romanick had been experiencing. During the conversation, Mr. Romanick's father received a text message from his son that suggested he was saying goodbye and advised the ESU team lead. Mr. Romanick had also sent a similar text message to his common-law spouse.

9 When the police were able to gain safe entry into the detached garage, they discovered Mr. Romanick on a couch with a shotgun and a bullet wound through his head. He was pronounced dead at the scene at 2:11 p.m.

10 In addition to the unfolding of the events on September 15, 2017, the inquest explored the circumstances of Mr. Romanick's attendance at the Emergency Department of the WRH on July 11 and September 12, 2017.

11 On July 11, 2017, Mr. Romanick attended the WRH Emergency Department voluntarily with his common-law spouse for help with depression and addiction. At triage, he was requesting detox protocol for cocaine, crack and crystal meth use, and a psychiatric assessment. The hospital records indicated that a bed was available for him, however, the social worker progress notes indicate that Mr. Romanick advised that he had contacted Detox and was informed that it may be more appropriate for him to speak with a psychiatrist. Mr. Romanick advised that he had never been formally diagnosed with a mental illness and that he has a family history of mental illness — brother has depression, father has ADHD and depression. Ultimately, Mr. Romanick was provided with a referral to the Transitional Stability Center, a psychiatric consult, and advised to consider individual counselling.

12 The jury heard evidence that Mr. Romanick's common-law spouse was present with his consent during his interview with the social worker and that during the interview, Mr. Romanick advised that he had a plan to kill himself with a gun. The progress notes made no reference to that, and the social worker had no independent recollection of the July 11, 2017, meeting.

She testified that her practice would have been to have made a note of such information, and that type of information would be relevant to a physician's decision to involuntarily admit Mr. Romanick for examination for up to 72 hours under Section 17 of Ontario's Mental Health Act. The social worker also testified that she had taken courses since 2017 that she found useful in equipping social workers with enhanced ways to probe suicidal ideations.

13 On September 12, 2017, after the second police attendance at his residence that day, Mr. Romanick was taken to the Emergency Department of the WRH, this time by ambulance, followed by a WPS officer. He was a person in crisis and in a delusional state.

14 His father, Clare Romanick, attended the hospital and spoke to both the social worker and the Emergency Room doctor urging them to admit his son as an in-patient. The jury heard that there was a disjuncture in the presentation of Mr. Romanick to the Social Worker and Emergency Physician versus what was communicated by Mr. Romanick's father and what was in the possession of the police. In particular, the police information that Mr. Romanick had a plan to hang himself with a guitar string the previous day appears not to have been passed on to the Emergency Room doctor or the social worker. The jury heard evidence that this information was relevant to a decision to involuntarily admit Mr. Romanick for examination for up to 72 hours under Section 17 of Ontario's Mental Health Act.

15 The jury heard that many changes designed to improve service delivery and support for persons with acute mental illness and/or psychosocial crisis have been implemented since 2017 in the healthcare and policing communities. The jury also heard evidence about the significant increase in demand for supports for persons in crisis, and the innovative initiatives and pilot programs that have been developed to assist with addressing the increased demands.

THE INQUEST

16 Dr. Elizabeth Urbantke, Regional Supervising Coroner, West Region, London Office, called a mandatory inquest into the death of Chad Romanick pursuant to section 10 of the Coroners Act.

17 The document outlining the scope of this inquest is attached as an Appendix.

18 The inquest was conducted in a virtual manner, with remote participation by parties with standing and remote testimony from all witnesses. In keeping with the open court principle, the inquest was streamed live.

19 The jury sat for seven days, heard evidence from 14 witnesses, reviewed 22 exhibits and deliberated for five hours in reaching a verdict.

VERDICT

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Name of Deceased:	Chad William Romanick
Date and Time of Death:	15 September 2017 at 2:11 pm
Place of Death:	1502 Betts Ave, Windsor, ON N9B 3L3
Cause of Death:	Shotgun wound to the head
By What Means:	Suicide

RECOMMENDATIONS

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To: Windsor Police Service (WPS)

1. Subject to operational exigencies, ensure that all calls for assistance and/or offers of assistance from the Windsor Police Service Emergency Services Unit that originate from an outside police service, be routed through the E911

Communications Centre to enhance information access, management, and facilitation of efficient communication among the agencies involved.

Comment:

The jury heard evidence from various witnesses on how the call for service of WPS was initiated by the Amherstburg Police Service (APS). Various law enforcement agencies were involved including the Windsor Police's Emergency Services Unit, members of the province's Repeat Offender and Parole Enforcement team and officers from the former Amherstburg Police. The jury heard that schools were concerned about the Windsor Police Emergency Services Unit presence on Betts Avenue in Windsor, on Friday, Sept. 15. 2017, of which the 911 dispatcher was not aware when a call in was made about how to deal with the school children who would have been leaving school. The jury also heard that protocols and standing orders exist for the deployment of police resources at WPS including the decision tree on what resources to be deployed and what, if any, information will be provided to the officers.

2. Incorporate the two 911 calls made by Chad Romanick into existing scenario-based training for 911 Communicators with respect to calls involving persons in crisis and consider developing a Checklist for communicators specific to persons in crisis.

Comment:

The jury heard evidence of Mr. Romanick's two calls to 911 on September 12, 2017, and how he presented to the operator: whispering and unresponsive for a lengthy period of time. It was apparent that he was not well. That information was not effectively communicated to the primary officers who attended the scene in response to two calls Mr. Romanick made for a break and enter. The second 911 call was handled by the same call-taker, in a less than ideal manner as the call-taker appears to have experienced frustration and ended the call prior to police arrival at Mr. Romanick's home. The WPS Communications Director testified that these calls would be useful to incorporate in training scenarios for 911 communicators.

3. Provide enhanced training for Windsor Police Service officers, 911 Communicators, dispatchers, and others accessing the CAD system on limitations and query results. Generated by means of matrices or other reference chart(s), deliverable by memo and/or directive(s).

Comment:

The jury heard that responding police officers on September 15, 2017, were not able to view or have ready access to the WPS records regarding Mr. Romanick's interaction with police and hospital attendance on September 12, 2017. The officers responding were not aware of the report from the same address, days earlier, involving Mr. Romanick and that he was a person in crisis. This information, if available, could have potentially been useful to them had Mr. Romanick responded to them and from an officer safety perspective. The jury also heard evidence that the CAD system was already being upgraded to search by address and/or name; however, the Director of Communications for Windsor Police Service spoke of limitations in terms of accessing real time information and difficulties attached to searching by name.

4. Explore opportunities to enhance 911 Communicator training with scenario-based approaches that include role-playing situations where crisis intervention and de-escalation techniques are needed in cases where calls evolve into PIC (Persons-In-Crisis) calls.

Comment:

The jury heard evidence that training in crisis intervention and de-escalation techniques are not routinely provided to 911 operators. They also heard evidence that a call for service can quickly evolve into a person in crisis situation. The jury heard evidence that more training for call-takers and dispatchers could be useful.

5. Explore opportunities to implement continual refresher training plans or courses for 911 Communicators for crisis intervention and de-escalation techniques with scenario-based approaches that may include role-playing situations.

Comment:

The jury heard that 911 communicators receive mandatory training when hired. However, there was no schedule, standard or guideline to refresh and update dispatchers on the different approaches to crisis intervention and de-escalation techniques in dealing with persons in crisis.

To: Windsor Police Service (WPS), Windsor Regional Hospital (WRH), and Hotel Dieu Grace Healthcare (HDGH)

6. Working through the Police-Hospital Committee, that the Windsor Police Service consider adding the Crisis Response Team ("CRT"), which includes a social worker and/or Nurse Police Team ("NPT'), which includes a nurse and a patrol police officer, be added to the "Emergency Callout" list on Code 200 calls at the discretion of a Critical Incident Commander.

Comment:

The jury heard that the Emergency Service Unit can be dispatched to serious incidents that involve apprehension of wanted persons some of whom are in crisis. The jury heard evidence that Crisis Response Teams ("CRT") and/or Nurse Police Teams ("NPT") provide a rapid and effective response to situations involving a person in crisis. This recommendation contemplates adding these specialized teams to the Emergency Call Out list at the discretion of a Critical Incident Commander, having regard to relevant safety considerations, when a person known to be in crisis is required to be arrested for a serious offence.

7. Working through the Police-Hospital Committee, identify opportunities for additional coordination with the WRH, HDGH and WPS, including but not limited to:

- Crisis response teams
- Nurse Police Team (NPT)
- Dedicated Hospital Officer/Code Crisis Pilot Project

This would include establishing more formal arrangements /protocols to determine which mobile crisis team should be strategically deployed to a crisis call and optimizing hours of coverage to meet service demands.

Comment:

The jury heard evidence about the increased demand for specialized teams for persons in crisis and scarcity of resources and coverage to meet the increasing demand. The jury also heard evidence that it could be the case that both NPTs and CRTs attend at the same call. The jury considered that better collaboration and coordination amongst the hospitals and the WPS could help optimize coverage and avoid having two specialized teams attend the same call.

To: Windsor Regional Hospital (WRH) and Hotel Dieu Grace Healthcare (HDGH)

8. Explore the availability of training and/or resources to enhance the ability of healthcare professionals involved in assessing patients with mental health presentations in their ability to receive and assess the reliability, validity, and potential significance of collateral information, with a view to incorporating into existing training.

Comment:

Mr. Romanick was a person in crisis and in a delusional state when he was taken to the hospital escorted by the WPS. His father, Clare Romanick, spoke to both the social worker and the doctor urging the doctor to admit his son as an in-patient. The jury heard that there was a disjuncture in the presentation of Mr. Romanick to the Social Worker and Emergency Physician versus what was communicated by Mr. Romanick's father and what was in the possession of the police.

9. Review existing training to consider implementation of CALM (Counselling on Access to Lethal Means) training into the existing required training plan for mental health healthcare workers.

Comment:

The jury heard that no questions were asked by the Social Worker and Emergency Physician on whether Mr. Romanick had access to firearms and ammunition.

10. Collaborate with local mental health and addictions partners, in consultation with other relevant stakeholders, to share resources for families, caregivers, and loved ones of Persons in Crisis (PIC) that will assist with accessing the available supports in community mental health and addiction services.

Comment:

The jury heard from Mr. Romanick's common-law spouse of the difficulty in accessing mental health and addiction services. She testified that she would like a recommendation where there should be a one-stop, wrap-around mental health services for people in crisis who reach out for help.

11. Collaborate with local mental health and addictions partners, in consultation with other relevant stakeholders, to explore opportunities to expand existing follow-up services to include more touchpoints with patients to ensure referral plans are proceeding and to assist in accessing the available supports in community mental health and addiction services.

Comment:

See comment 10 above.

12. Collaborate with local mental health and addictions partners, in consultation with other relevant stakeholders, to explore feasibility to provide follow-up services for families, caregivers, and loved ones who have experienced trauma as a result of a loved one's mental illness and/or addiction offered through various means (examples include: card, brochure, text/call/email follow-up opt-in) to ensure multiple means of access to existing services in the community.

Comment:

The jury heard evidence regarding challenges with navigating and accessing mental health supports for families, caregivers, and loved ones of a person in crisis, and the vicarious and firsthand trauma that can be experienced because of a loved one's mental illness and/or addiction. The jury heard of various efforts to improve legibility and access to information for support to families, caregivers, and loved ones who labor under difficult circumstances.

13. Collaborate with relevant stakeholders on the feasibility of expanding the services offered through the Mental Health Addiction Urgent Care Clinic (MHAUCC) to provide 24-hour coverage for persons in crisis.

Comment:

Currently the MHAUCC, which offers walk-in service for anyone over the age of 16 "who cannot safely wait for community mental health and addiction support," is open between 11:00 a.m. and 7:00 p.m. The jury heard evidence from an Inspector about the difficulty police have when an apprehension is made outside of those hours and the challenges of persons who do not meet the criteria for apprehension under the Mental Health Act but require support. The jury heard that there is a need for real-time access to services for persons in crisis, which in turn would help ease the demand on the Windsor Regional

Hospital Emergency Department. The jury also heard evidence that Hotel Dieu Grace Healthcare has been working to achieve a stand-alone 24-hour availability of MHAUCC for persons in crisis.

14. Collaborate with local mental health and addictions partners, in consultation with Ontario Health and other relevant stakeholders, to establish targets for timely access to mental health and addiction services. This should include developing and implementing evidence-based target timelines in the assessment and treatment of patients presenting with the most urgent categories of mental health and addiction concerns.

Comment:

The jury heard evidence that the coding system for patients in the Emergency Department can lead to difficult triage decisions as between a critically wounded or ill patient versus a person in crisis. The jury heard evidence regarding a Dedicated Hospital Officer/Code Crisis Pilot Project with the Windsor Police Service. This recommendation encourages all health care partners, Ontario Health, and other stakeholders to collaborate on prioritizing care for persons presenting with significant mental health and addiction concerns.

15. Collaborate with local mental health and addictions partners, in consultation with Ontario Health and other relevant stakeholders, to: (1) establish a common definition of "wait time" (as many organizations define and track wait times differently); and (2) make wait times available to partners to inform planning and referral.

Comment:

The need for a common understanding across healthcare partners of "wait times" in the context of referrals was evident from the evidence the jury heard.

CLOSING COMMENT

22 In closing, I would like to again express my condolences to the family, particularly Sherry Lamas and the children inclusive of the twins, and friends of Chad Romanick, for their profound loss. Hopefully this verdict explanation will provide him those answers.

23 I would like to thank the witnesses and parties to the inquest for their thoughtful participation, and to thank the inquest counsel, investigator, and constable for their hard work and expertise. I would also like to thank the members of the jury for their commitment to the inquest.

24 One purpose of an inquest is to make, where appropriate, recommendations to help prevent further deaths. Recommendations are sent to the named recipients for implementation and responses are expected within six months of receipt.

25 I hope that this verdict explanation helps interested parties understand the context for the jury's verdict and recommendations, with the goal of keeping Ontarians safer.

Appendix

STATEMENT OF SCOPE

Inquest into the Death of Chad William ROMANICK

This inquest will look into the circumstances of the death of Chad William Romanick and examine the events of his death on or about September 15, 2017, to assist the jury in answering the five mandatory questions set out in s. 31(1) of the Coroners Act.

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death;

(d) where the deceased came to his or her death; and

(e) by what means the deceased came to his or her death

Specifically, beyond the facts required to accurately answer the five questions and understand the circumstances of the death, we will be addressing the following issues to the extent that these issues may have relevance to potential recommendations:

1. The circumstances surrounding the death of Chad William Romanick;

2. Police training concerning interaction with, and potential apprehension of, emotionally disturbed persons.

3. Services to families/loved ones with respect to accessing psychological/ psychiatric/medical carte for a person with suspected mental health issues.

4. Availability of MCIT teams as opposed to ESU in these circumstances.

Excluded from the scope will be any in-depth exploration of the following:

1. Emergency or first-aid response provided to Mr. Romanick after the self-inflicted gunshot;

2. The SIU investigation into the shooting.

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