

# Ministry of Public Safety and Solicitor General

File Number: 2016-1030-0085

# Province of British Columbia

# **VERDICT AT CORONERS INQUEST**

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

BOUCHER				ANDRE CLAUDE			
Surname					GIVEN NAMES		
An Inquest was held at The Victoria Law Courts			v Courts	, in the municipality of	Victoria		
in the Provinc	in the Province of British Columbia, on the following da			May 14, 2018 t	o May 16, 2018		
before:	Michael Eg	ilson		, Presiding Coroner.			
into the death of			Andre	Claude	60 X Male Female		
			(First Name)	(Middle Name)	(Age)		
The following findings were made:							
Date and Tim	ne of Death:	August 7, 2016		15:25			
		(Date)			(time)		
Place of Deat	h.	Victoria General Hospita		tal	ВС		
Flace of Deat		(Location)	Ocheral Hospi	lai	(Municipality/Province)		
Medical Caus	e of Death:						
(1) Immediat	te Cause of De	ath: a) Suba	rachnoid haemo	orrhage			
		Due to or	as a consequence	e of			
Antecedent C	ause if any:	b) Rupt	tured Cerebral A	Artery ('berry') aneury	sm		
	Due to or as a consequence of						
Giving rise to the immediate cause (a) above, stating cause last.							
(2) Other Significant Conditions Hypertension Contributing to Death:							
Classification of Death: Accidental Homicide X Natural Suicide Undetermined							
The above verdict certified by the Jury on the16 day ofAD,2018							
N. T. O.G. O							
Michael Egilson  Presiding Coroner's Printed Name  Presiding Coroner's Signature					Coroner's Signature		



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**ANDRE CLAUDE** 

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SURNAME

GIVEN NAMES

#### PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Michael Egilson

Inquest Counsel: John M. Orr, QC

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: None

The Sheriff took charge of the jury and recorded 7 exhibits. 16 witnesses were duly sworn and testified.

#### PRESIDING CORONER'S COMMENTS (JUNE 15, 2018):

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

This inquest dealt with the death of Andre Claude Boucher who died at the Victoria General Hospital as the result of a subarachnoid haemorrhage as a consequence of a brain aneurysm.

Mr. Boucher was described by his sister, his doctor and the police as a gentle human being. On July 17, 2016 in the evening a citizen called the Saanich Police Department to report a man stumbling and falling over in a neighbour's yard. The citizen reported that the man was having difficulty standing up. The Saanich Police responded to the call and located a man a short time later in the middle of a residential street staggering and using his arms for balance. When questioned, the man identified himself as Andre Boucher and also provided his birthdate. Mr. Boucher was observed to be slurring his speech, smelled of alcohol and he informed the police that he was an alcoholic during their conversation.

After observing and questioning Mr. Boucher the Saanich police officers in attendance concluded that there was no responsible person into whose care they could release Mr. Boucher. A police officer informed Mr. Boucher that he would be placed under arrest for public intoxication and taken to the Saanich Police cells for his own safety but that he was not being charged with any crime. Mr. Boucher was cooperative with the police and was taken a short distance to the Saanich Police detachment in the back seat of a police vehicle. Once at the station, Mr. Boucher was booked and placed in a jail cell at approximately 11:30 pm. No injuries were observed on Mr. Boucher at the time of his arrest or at the time of his booking.



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Mr. Boucher was restless in his cell for the next several hours and was monitored by a Saanich jailor by video monitor and in person every 15 minutes as per Saanich Police Department policy. The Saanich police plan was to release Mr. Boucher when deemed no longer intoxicated but Mr. Boucher's perceived intoxication did not appear to lessen throughout the night. Shortly after 10 am on July 18, 2018, Mr. Boucher fell off of his bed and struck his head and then he stood up. The jailor reported Mr. Boucher's fall to the desk officer and watch commander who attended the cell at 10:15 am. A minute later Mr. Boucher fell again and was assessed by the police officers. Mr. Boucher was jittery and noncommunicative. At this point the police called the Emergency Health Services to assess Mr. Boucher. Emergency Health Services attended to Mr. Boucher at 10:28 am and after assessing Mr. Boucher assisted him on to a stretcher and transported him to the Victoria General Hospital. Once on the stretcher an abrasion was noted on the top of Mr. Boucher's head.

Mr. Boucher arrived at the hospital at approximately 11 am and was seen by an emergency room physician. Mr. Boucher was agitated and confused upon arrival. Mr. Boucher was initially assessed as displaying toxic drug delirium but he was administered a computed tomography (CT) scan to determine whether Mr. Boucher's agitation and confusion was the result of a head injury. The CT scan revealed a brain haemorrhage and Mr. Boucher was prepared for surgery. A neurosurgeon placed a drain in Mr. Boucher's head to relieve the pressure on his brain and better understand the impact of the haemorrhage. Over the next few days Mr. Boucher's showed some improvement and after consulting with Mr. Boucher's sister a neurosurgeon performed surgery on August 3, 2018, to treat Mr. Boucher's aneurysm before it re-ruptured.

Two neurosurgeons informed the jury that Mr. Boucher's ruptured aneurysm was not trauma induced because of its size, shape, location and the nature of the bleeding. The jury heard that the prognosis of survival from a severe aneurysm is very poor. Mr. Boucher's aneurysm was described as a catastrophic bleed that would have been sudden and very difficult to recognize to an untrained eye. None of the surgeons was able to predict when exactly the aneurysm ruptured but estimated it would have been several hours at most.

Mr. Boucher suffered a stroke during the surgery and his clinical condition became worse. The prognosis for Mr. Boucher was poor and after discussions with his family they opted for comfort care. Mr. Boucher died a short time later on August 7, 2018 at 3:25 pm.



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Pursuant to Section 38 of the Coroners Act, the fo the Province of British Columbia for distribution to	ollowing recommendations are forwarded to the Chief Coroner of the appropriate agency:
JURY RECOMMENDATIONS:	
None.	