Ministry of Public Safety and Solicitor General

File Number: 2017-0380-0001

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

SAKAMOTO	Charlene Teresa
SURNAME	GIVEN NAMES

An Inquest was held at Burnaby Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates: Oct 9-11, 2018

before: Margaret Janzen, Presiding Coroner.

into the death of Sakamoto (Last Name) Charlene (First Name) Teresa (Middle Name) 39 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: January 24, 2017 (Date) 01:30 (time)

Place of Death: Chilliwack (Location) BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Anoxic brain injury

Due to or as a consequence of

Antecedent Cause if any: b) Opiate toxicity

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☒ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 11th day of October AD, 2018

Margaret Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	John M. Orr, QC
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mark Skorah, QC and Maria (Mimi) Willcock, counsel for BC Emergency Health Services

The Sheriff took charge of the jury and recorded 8 exhibits. 16 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

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.

Charlene Teresa Sakamoto was a 39 year old woman who was involuntarily admitted to the Chilliwack General Hospital in December, 2016. She had a history of schizoaffective disorder, manic depression, psychosis, and substance use. She had had multiple previous psychiatric admissions both voluntary and involuntary. She had been living in the community and was brought to hospital by the RCMP after her landlord reported concerning behaviour.

After her admission Ms. Sakamoto began to improve and was eventually allowed to go out on temporary passes from time to time. The ward was not locked and passes were granted to patients as part of their therapy.

On January 17, 2017, she asked her treating psychiatrist for a two hour unaccompanied pass to be used on January 18, 2017, to collect her disability cheque. The psychiatrist granted the pass and recorded the permission in her medical records. Before leaving on a pass, hospital protocol was that the patient would sign out with a nurse who would discuss the pass and its conditions with the patient, take note of the patient's appearance, and note the time the patient left.

On the morning of January 18, 2017, Ms. Sakamoto was at the nurses' station waiting to discuss her pass with the nurse but the nurse was occupied with other tasks at the time. At approximately 0745 hours Ms. Sakamoto was discovered to not be on the ward. The psychiatrist who was responsible for her care that day was notified and reviewed her records. It was noted that she had been given the pass and had been concerned about her cheque. The psychiatrist felt that she had likely tired of waiting for the nurse and had left without signing out. It was determined that she would be allowed the two hours as previously granted and she would not be reported as missing unless she did not return in two hours.

At 1010 hours Ms. Sakamoto had not yet returned and a Director's Warrant for her apprehension was issued and sent to the RCMP who informed their members to be on the lookout for her.

An RCMP officer who had had previous dealings with Ms. Sakamoto received the information that she was at large and realized that he had seen her outside a local strip mall. The officer returned to the mall and saw Ms. Sakamoto on the sidewalk smoking a cigarette. The officer spoke to her and she acknowledged that she was Ms. Sakamoto and that she was out on a pass. At approximately 1025 hours the officer informed her that she had exceeded her two hours and that she was being apprehended and taken back to hospital.

Ms. Sakamoto was cooperative and appeared to the officer to be behaving normally. Two civilians who were employed at businesses in the mall observed parts of the interaction between Ms. Sakamoto and the officer. They testified that the interaction with the officer was non-confrontational and Ms. Sakamoto did not appear to be impaired.

Ms. Sakamoto was handcuffed behind her back and placed in the back seat of the police car on the driver's side following a pat-down which revealed a glass crack pipe that appeared to be unused. The officer asked her if she had any drugs and she replied that she did not but had been looking for some. The officer informed her of her Charter rights which consisted of three statements, each followed by asking whether she understood. She responded to the first question by saying that she understood but did not reply to the second or third question. The officer then drove Ms. Sakamoto to the Chilliwack General Hospital, arriving at the psychiatric unit area at approximately 1038 hours.

When the officer opened the back door of the police car to remove Ms. Sakamoto, he realized that she was unresponsive. When she could not be roused, he closed the door and drove to the emergency department, where he requested assistance from a nearby paramedic. The paramedic quickly finished with his current patient and came to assist the officer. The officer removed the handcuffs. The paramedic could not find a pulse. He described her pupils as fixed and dilated.

Together they attempted to remove Ms. Sakamoto from the car but her feet were stuck under the driver's seat. She had on bulky winter clothes and boots, and was quite heavy so it took them approximately two minutes to remove her. Once extracted, she was placed on a portable bed, chest compressions were started, and she was taken into the emergency department.

In the emergency department resuscitation efforts continued. Naloxone, the antagonist for opiates, was administered three times and after the third dose at 1100 hours a pulse was regained. A drug screen was conducted which showed the presence of opiates. Ms. Sakamoto was diagnosed with an anoxic brain injury. She was placed on life support and transferred to the intensive care unit. Further diagnostic tests were undertaken which

showed that Ms. Sakamoto's brain injury was severe and that she would not recover. She was removed from life support and died at the Chilliwack General Hospital on January 24, 2017, at approximately 0130 hours.

A toxicology examination on hospital blood and urine samples, obtained by the BC Coroners Service, revealed the presence of fentanyl and heroin in addition to Ms. Sakamoto's prescribed medications.

The Independent Investigations Office of BC investigated the incident and determined that the actions or omissions of the police officer did not appear to have contributed to the cause of death of Ms. Sakamoto.

Following this incident, the Fraser Health Authority reviewed its policies regarding passes for psychiatric patients and a number of changes were instituted, including providing patients who were known to use substances with naloxone kits when they went out on passes and upon discharge.

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Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

No recommendations.