Ministry of Public Safety
and Solicitor General
Coroners Service
Province of British Columbia

File No. :2018:1038:0053

# 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

| **Eurchuk** | **Elliot Cleveland** |
|---|---|
| SURNAME | GIVEN NAMES |

An Inquest was held at The Fraser Building, University of Victoria, in the municipality of Oak Bay

in the Province of British Columbia, on the following dates June 18 through June 27, 2019

before: Michael Egilson, Presiding Coroner.

into the death of Eurchuk (Last Name) Elliot (First Name) Cleveland (Middle Name) 16 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: April 20, 2018 03:30 hours

Place of Death: 2714 Lincoln Road (Location) Oak Bay, BC (Municipality/Province)

Medical Cause of Death:

*(1) Immediate Cause of Death:* a) Mixed intoxication with fentanyl, cocaine, heroin, and methamphetamine with aspiration, pulmonary edema, and acute myocardial infarction

Due to or as a consequence of

*Antecedent Cause if any:* b)

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 27 day of June AD, 2019

Michael Egilson
***Presiding Coroner's Printed Name***

***Presiding Coroner's Signature***

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## 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: | Michael Scherr, counsel for Family |
| | Rolf Warburton and Fernando de Lima, counsel for Province of British Columbia |
| | Dean Lawton and Karen Orr, counsel for Island Health |
| | David Pilley counsel for Dr. Lauren Kitney, Dr. Krystal Cullen, Dr. Brenda Copen, Dr. Mary Nixon, Dr. David Harrison, Dr. Jennifer Balfour, Dr. Brent Weatherhead, and Dr. Marjorie Ann Van der Linden |
| | Lee Mauro counsel for Greater Victoria School District 61 |

The Sheriff took charge of the jury and recorded **8** exhibits. **42** 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.*

Elliot Cleveland Eurchuk was a 16-year-old youth described by his parents as a bright young man, involved in sports and with a number of good friends.

On the morning of April 20, 2018, Elliot's mother found him in his bedroom, unresponsive and not breathing. Elliot's father called 911 and began CPR. Oak Bay Police arrived at 0731 and located Elliot on the floor of his bedroom. A police officer took over CPR until the Oak Bay Fire Department arrived at 0734 and continued chest compressions, suction of Elliot's airways and attached an automatic external defibrillator (AED) which indicated Elliot did not have a shockable heart rhythm. Paramedics arrived and completed an assessment. Resuscitation efforts were ceased at 0742 as a result of obvious signs of death. Illicit drug paraphernalia were in the room as were used capsules of naloxone that had been administered by Elliot's mother.

The police investigation determined that Elliot's death was not suspicious. Neither the police, emergency responders nor Elliot's family found any type of suicide note.

A toxicologist determined that he had ingested fentanyl (within a range where lethal outcomes occur), cocaine (in a range where non-lethal concentrations overlap with fatal overdoses), heroin and methamphetamine.

The pathologist, who performed the autopsy, found evidence of healing incisions and cuts consistent with self-inflicted injuries but no physical abnormalities to account for Elliot's death. The pathologist concluded that Elliot died as a result of mixed intoxication with fentanyl, cocaine, heroin and methamphetamine with aspiration, pulmonary edema, and acute myocardial infarction.

Elliot's father stated that Elliot had sustained two concussions at a rugby camps in his grade 8 and 9 years. Elliot was assessed on the field, but no further medical examination occurred.

Elliot's cannabis use was first identified in November 2015.

Elliot injured his shoulder during wrestling practice around May 2016. He had an MRI in August 2016 and it was determined that he would require surgery to repair his shoulder. Elliot took Dilaudid, an opioid also known as hydromorphone, which he obtained from another student, in the fall of 2016. Elliot's use of opioids escalated, and his consumption of cannabis increased. In November 2016 Elliot's mother found a bag of various drugs in his room and reported this to the school. Some of these drugs appeared to be from her dental office.

In December 2016, Elliot's jaw was broken during a soccer match. Elliot had a second surgery on his jaw on January 13, 2017. Elliot's broken jaw delayed his shoulder surgery. Elliot had his first shoulder surgery on February 2, 2017 and was prescribed a five day course of hydromorphone for pain management. Elliot re-injured his shoulder in the spring of 2017 and an MRI in September 2017 showed the initial shoulder surgery had failed. Elliot was prescribed Tramacet, an opioid, by his doctor on September 27, 2017.

Elliot was suspended from Oak Bay High School in September 2017 for allegedly providing drugs to other students. He appeared before a principals' review committee where the outcome was Elliot being placed at Mount Douglas Secondary School.

Elliot had a second shoulder surgery October 9, 2017 and was prescribed a five day course of Oxycodone (an opioid). This was prescribed instead of hydromorphone because the surgeon had been notified of Elliot's drug use. At a two week follow up appointment, Elliot was prescribed Tramacet for pain.

A peer of Elliot said that Elliot was dependent on opioids in grade 11 and using opioids every couple of days. Elliot was reported to have bought heroin off the dark web.

Elliot and his parents were referred to community counselling services as part of the outcome from Elliot's principals' review committee in September 2017 and he attended in November 2017. Elliot disagreed with his removal from Oak Bay High School and wanted to return there. Elliot did not want to be in counselling, denied any drug use and believed he had no choice regarding attending counselling.

Elliot was screened for drug use in November 2017 by his physician and screened positive for opioids. Elliot's parents were aware of the results.

Elliot was admitted to Victoria General Hospital (VGH) with a serious infection in February 2018. While on a hospital pass Elliot obtained a mixture of fentanyl and cocaine. Elliot took the drugs and experienced a cardiac arrest while in hospital. He was revived with naloxone. Elliot is reported to have said that he wished he had died and that if he was put in a locked facility, he would become the worst drug addict imaginable or he would kill himself.

Elliot was assessed by a psychiatrist who described Elliot as quiet and reserved as well as not being forthright about his drug use. The psychiatrist was concerned about family conflict in the home, Elliot's drug use, his willingness to engage in services and Elliot managing his drug use. Elliot did not wish to be in the hospital, and he was not deemed to have suicidal intent. A discharge plan included a discussion of harm reduction regarding drug use, supports for the family and information on services for Elliot.

Elliot was readmitted to VGH under the *Mental Health Act* later in February 2018 and discharged approximately one week later. A psychiatrist testified that there were no grounds to detain Elliot for psychiatric reasons. Elliot was confused as to why he had been admitted. He was pleasant, cooperative and not expressing suicidal ideation. At that time, Elliot was concerned about catching up on his subjects at school. The psychiatrist testified that Elliot was aware of the risk of opioid drug use but also stated that Elliot's insight and judgement around drug use were compromised. The psychiatrist met with Elliot's parents to review his discharge plan.

Elliot was brought to the emergency department at St. Paul's hospital in Vancouver in March 2018 because of his decreased state of consciousness. He remained there for several hours and was released. Drug testing was not undertaken.

A number of counsellors, physicians and school personnel testified that Elliot was polite and well-mannered but not wanting to engage or acknowledge his drug use.

Elliot usually obtained his drug supply through a website where drugs are rated by visitors.

The day before he died Elliot purchased some drugs downtown that were more powerful than those Elliot usually consumed, according to Elliot's friend. Elliot consumed opioids with his friend and left while highly intoxicated, sometime in the early evening. He took what was described as a two-day supply of the drug with him. Elliot and his friend had discussed death that night, in terms of the risk of taking opioids. Elliot texted his friend later in the evening that he was excited to go to the gym the following day to work out.

People who saw Elliot between approximately 10:00 PM and midnight on the evening prior to his death, described him in a variety of ways from seeming fine to seeming agitated and disoriented. Elliot was last seen alive parting company with friends near Cattle Point around midnight.

During hospital admissions in February 2018 and appointments with his physicians and counsellors, Elliot expressed his desire for confidentiality and did not want information shared with his parents.

Several counsellors and physicians provided their views to the jury around confidentiality and information sharing when dealing with competent minors. They stressed the importance of the therapeutic relationship.

Counsellors, physicians and policy experts spoke about acute and community youth addictions services in British Columbia and the adequacy of those services both at the time of the inquest and at the time of Elliot's death. Evidence was also provided regarding involuntary care for youth with substance use disorders and on the impact of the opioid crisis on youth. The jury also heard about the Province's new plan for mental health and addictions and how it relates to young people.

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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:**

**To: Minister of Education**

1. Develop processes for early detection of mental health and substance use disorders within the schools.

   **Presiding Coroner Comment:** *The jury heard evidence from multiple mental health professionals that early detection of mental health and substance use disorders was the best way to prevent prolonged drug use and dependence in youth.*

2. Develop and implement a plan to transition youth from acute care and addiction treatment facilities to schools.

   **Presiding Coroner Comment:** *The jury heard evidence that schools need to be part of planning for youth when they leave acute care treatment facilities in order to address safety concerns and ensure that appropriate supports are in place for the student.*

3. Provide education to students, parents or guardians, teachers and administrators on mental health and substance use disorders.

   **Presiding Coroner Comment:** *The jury heard testimony that School District 61 provided students, parents, educators and administrators with timely information on facts and issues around substance use and mental health disorders through "Snapshots". The jury further heard that the information was well received and helpful.*

**To: Minister of Health**

4. Develop and implement a plan to transition youth from health care facilities back to community based services.

   **Presiding Coroner Comment:** *The jury heard testimony that transition planning from acute care facilities to community based services was inconsistent and was required in order to ensure continuity of care and adequacy of support to young people.*

5. Streamline and coordinate access to available youth residential substance use disorder treatment beds and youth mental health care beds within British Columbia.

   **Presiding Coroner Comment:** *The jury heard evidence that there are limited residential resources for youth and that access to those resources may be restricted based on where a young person lives within the province.*

6. Provide youth with more long term residential substance use disorder treatment facilities throughout British Columbia.

   **Presiding Coroner Comment:** *The jury heard testimony from multiple health care professionals that there is a shortage of mental health and substance use disorder residential resources within British Columbia.*

**To: CEO of Island Health**

7. Provide youth with long term residential substance use disorder treatment facilities to be located on Vancouver Island.

   **Presiding Coroner Comment:** *The jury heard testimony that there are no long term residential treatment facilities for youth on Vancouver Island.*