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

File No. :2014:0420:0060

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

SETAH	Jacob George
SURNAME	GIVEN NAMES

An Inquest was held at Kamloops Court House, in the municipality of Kamloops

in the Province of British Columbia, on the following dates APRIL 11 – 14, 2016

before: Margaret Janzen, Presiding Coroner.

into the death of SETAH (Last Name) Jacob (First Name) George (Middle Name) 18 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: June 15, 2014 23:56 HOURS

Place of Death: ROYAL INLAND HOSPITAL (Location) KAMLOOPS, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Blunt trauma brain damage injuries

Due to or as a consequence of

Antecedent Cause if any: b) Blunt trauma injury to head

Due to or as a consequence of

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

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 14 day of April AD, 2016

Margret Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	Mr. Roderick H. MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. David Kwan, Attorney General of Canada/ Ms. K. Yee, Dr. B. Olabiyi and Dr. E. Englebrecht/ Dr. J.D. Cotter, Interior Health Authority/ Mr. D. King, Yunesit'in (Stone) Government

The Sheriff took charge of the jury and recorded 5 exhibits. 31 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. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Findings and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's Findings and Recommendations.

Jacob George Setah was from the Yunesit'in First Nation's Stone Reserve #1 on the Chilcotin River approximately 100 km from Williams Lake. He grew up on the Reserve and attended the K-7 school there then moved to Williams Lake in grade eight. Between terms, during holidays, and after he left school he lived on the reserve or in Williams Lake. Extended family members were also in his life and he spent time at their homes as well, particularly with his cousins.

Jacob's medical history was unremarkable until approximately the age of 17 when family members began to see Jacob exhibit behaviours that concerned them. On December 2, 2013, he was taken by a family member to the Cariboo Memorial Hospital after exhibiting concerning behaviour. Physicians felt he was having a psychotic episode. His family physician saw him and prescribed olanzapine, a short-acting medication prescribed for hallucinations and anxiety which is generally well-tolerated. Within a few days his symptoms had resolved enough for him to be sent home on medication with a recommendation that he be followed up in the community and get help for substance abuse.

In June, 2014, extended family members took him to see a psychiatric nurse at the Denisiqi Services Society in Williams Lake on an urgent basis after other family members expressed alarm at his condition. Jacob did not appear to be rational at times. Family members were concerned for their own safety as well as Jacob's. The nurse recommended that he be evaluated by a physician so he was taken to the Cariboo Memorial Hospital in Williams Lake. A forensic psychiatrist assessed Jacob and determined that he was exhibiting symptoms of paranoia and schizophrenia. He signed the first certificate under the *Mental Health Act* effectively committing Jacob until another physician could assess him. He also prescribed olanzapine. Jacob's family physician attended the hospital the next day and after assessing him signed the second certificate required for committal under the *Mental Health Act*.

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Jacob was admitted to the Cariboo Memorial Hospital on June 9, 2014, while a bed was found for him at a designated facility. The Royal Inland Hospital was the closest such facility and he was transferred there on June 11, 2014. He was admitted to the Special Care Unit of One South ward for observation and stabilization. The Special Care Unit was the locked part of the ward. He was seen by a child and adolescent psychiatrist who developed a working diagnosis of psychosis with escalating paranoia and hallucinations. Jacob was prescribed the antipsychotic quetiapine.

Although ward staff reported that he was generally pleasant and cooperative Jacob appeared to be bored and exhibited psychotic symptoms. Although patients in the rest of the ward might be granted passes to leave the ward or go outside patients in the Special Care Unit were not allowed passes. A security guard was stationed by the door at a desk. The doors on the ward could be locked automatically by pressing a lock-down button on the wall near the desk. The button also sent an alarm out to other hospital security guards who were to respond to the ward to assist. The security guard's job was primarily to sit by the door at a small desk and push the button to lock the doors if a patient tried to escape

On June 15, 2014, at approximately 1915 hours Jacob was walking around the Special Care Unit. There was a washroom near where the security guard was sitting at his desk. Jacob appeared to be walking toward the washroom but then suddenly ran past the security guard. The guard stood up and grabbed Jacob by the arm briefly but Jacob got away and continued running down the hall. The guard hit the lock-down button. Jacob unsuccessfully tried to leave through the now locked doors. The guard called to him to come back and that it was going to be ok. Jacob raised his fist at the guard then went in to the television room and staff soon heard breaking glass. Another security guard who had arrived went down to the television room and could see that Jacob had broken a large window and was standing on the sidewalk outside. The guard told him to stop and Jacob ran off in a westerly direction.

Security guards followed Jacob. He went up to the fourth level of the hospital parkade and into the northwest corner. When security guards moved towards him he told them to back away or he would jump. The RCMP were summoned. At some point Jacob got up onto the concrete wall surrounding the parkade and then up onto an SUV which was parked in the corner. The space between the vehicle and the wall was very narrow. He went from the SUV to the concrete wall a number of times. There was a square metal railing on top of the wall which increased its height. Sometimes he would sit on the railing on top of the wall and sometimes he would stand up. One of the guards pleaded with him to come down and to sit down and told him the guards would not come closer. Jacob did not respond to this in a meaningful way.

The RCMP arrived at approximately 1930 hours. Two officers, a male and a female, proceeded to the top of the parkade where they found Jacob in the corner. He was dressed only in hospital pants and appeared to have blood on his chest and arms. The female officer tried to engage Jacob by asking him his name and what was going on. He did not respond to her questions but stated that he was a god and a warrior and not afraid to die. He got on top of the vehicle again and kicked the windshield out with his bare foot.

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He then got onto the concrete wall. He asked for a cigarette. Another RCMP officer located and passed cigarettes and a lighter to the female officer. She lit one and placed it on the concrete wall beside the vehicle and then backed away. Jacob retrieved the cigarette and smoked it while on top of the railing. This scenario was repeated twice more but each time the officer put the cigarette a little further from the SUV and closer to the RCMP.

As the two officers were talking to Jacob three other officers were also present but stayed mostly away from Jacob's line of vision. Their roles were support and planning focused. One officer went to One South and obtained Jacob's name and history. She was advised that Jacob was a risk to harm himself or others. This information was conveyed to the officers in the parkade. While some witnesses testified that they were alert to the possible danger to themselves that Jacob's mental state represented no one testified that they felt threatened by Jacob or that he advanced upon them in a threatening manner.

At approximately 2009 hours Jacob requested the third cigarette. The female officer lit it and told her fellow officer to be ready. She placed the lit cigarette on the ground in front of the vehicle. Jacob objected to the cigarette's placement but came down and picked it up. At that time the male officer fired his Taser. Both probes attached to the Taser appeared to have struck Jacob in the chest. He fell to the ground. Both officers rushed forward but Jacob immediately got back up and ran into the corner again. He jumped on top of the railing then jumped off, landing on the hard surface of the forecourt of the emergency department below.

Paramedics who had been alerted to the situation had been waiting and went to Jacob's side immediately along with an emergency room nurse. Jacob was unconscious and unresponsive. It was apparent that he had suffered severe trauma and he was taken into the hospital. Physicians began treatment and diagnosed him with a depressed comminuted skull fracture, extensive internal injuries, and fractures of his lumbar vertebrae with obvious spinal cord injury. His injuries were non-survivable and he died at the Royal Inland Hospital 2356 hours on June 15, 2014.

The Independent Investigations Office (IIO) investigated the incident in accordance with their mandate and determined that the RCMP officers had not committed any criminal offence. The Taser was examined and found to be in good working order

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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: First Nations Health Authority

1. Work with the Yunesit'in government to resource preventative measures or programs needed for early childhood and youth development to promote mental health.

Presiding Coroner Comment:

The jury heard evidence that the Stone Reserve had very few resources to provide basic health care and education let alone promote mental and preventative health in their children.

2. Dedicate financial assistance to families of youth that have been committed under the *Mental Health Act* and are forced to transfer to a dedicated psychiatric facility outside of their community to assist with travel so they can be there to provide support.

Presiding Coroner Comment:

Evidence was led that personal and band financial resources made it difficult if not impossible for families to travel with their children to designated facilities. It is approximately 388 km to Kamloops from the Stone Reserve. Many children with acute mental health issues are treated at the Kelowna General Hospital which is approximately 550 km from the Stone Reserve. At the time of the inquest there was reported to be 40% unemployment among adults living on the Reserve. Not all adults had vehicles and the cost of meals, fuel, and accommodations were prohibitive. The jury heard that a provincial Collaborative Action Team had reviewed the provision of mental health services and found that there were over one hundred barriers to access.

3. Explore expansion of video conferencing health services (including mental health services) to all remote communities.

Presiding Coroner Comment:

The jury heard evidence about the use of videoconferencing to provide health services. Use of this technology would allow people to stay in their communities and provide access to health care for people in remote communities throughout BC.

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To: Interior Health Authority:

4. Create an observation room for the Cariboo Memorial Hospital as quickly as possible where both adults and youth who have been committed under the *Mental Health Act* can stay for assessment.

Presiding Coroner Comment:

While Jacob stayed at the Cariboo Memorial Hospital in Williams Lake he could be, and was, visited by family who could support, advocate for, and help watch him. Evidence was led that there was a designated mental health room at the Cariboo Memorial Hospital for voluntary adult patients but that option was not available as Jacob was a minor at the time.

5. Establish that when youth are transferred out of their community to a designated psychiatric facility the receiving hospital should encourage and facilitate family involvement in their care where possible and appropriate.

Presiding Coroner Comment:

Jacob did not receive visitors while he was in the Special Care Unit at the Royal Inland Hospital. Family members wished to visit and wanted to give him money for his personal needs but were told they could not see him. Jacob's basic recent history was obtained from the extended family members who drove him to Kamloops and from Jacob himself. Other family members felt they could have contributed as well.

6. Enact a policy that states all psychiatric patients designated as 'Level 1' at Royal Inland Hospital should be seen daily by a psychiatrist.

Presiding Coroner Comment:

Jacob was not seen by a psychiatrist at the Royal Inland Hospital on June 14 or 15 because it was a weekend. The psychiatrist on call for the region was not expected to be physically present at the hospital or see patients for routine care.

7. Expand the Car 40 Program in Kamloops to operate 24/7.

Presiding Coroner Comment:

Evidence showed that the Car 40 Program (where a police officer with mental health training and a psychiatric nurse were available to attend at mental health calls) not did not operate on weekends.

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8. Proceed with the planned mental health facility at Royal Inland Hospital forthwith

Presiding Coroner Comment:

The jury heard evidence that mental health services provided by the Royal Inland Hospital were to be expanded when a new facility was built but that the expected start date was five to seven years in the future. The Royal Inland Hospital provides mental health services to a very large area and the jury heard that there were not enough places available in One South. This recommendation urges the Interior Health Authority to make this expansion of the One South facility a priority.

9. Give security personnel in mental health facilities specialized training to deal with their unique duties.

Presiding Coroner Comment:

A security guard testified that nothing in the training they received focused on dealing with mental health patients and that no changes to the training had been implemented as a result of this incident. This recommendation seeks to expand the security guards' mental health training.

10. Expand cultural sensitivity training for care providers when patient is presented to Royal Inland Hospital ER/admitting.

Presiding Coroner Comment:

This recommendation is self-explanatory.

11. Ensure all public areas of Royal Inland Hospital are covered by security cameras.

Presiding Coroner Comment:

The jury appears to have felt that monitoring cameras may have assisted in tracking Jacob's movement's or clarified the circumstances surrounding his death.

12. Add one more guard (total of two guards) in One South psychiatric ward at Royal Inland Hospital.

Presiding Coroner Comment:

Security guards testified that the duties of the guard assigned to One South prevented them from leaving their post at the desk when a patient proceeded past that point. No additional guards had been assigned to One South at the time of the inquest.

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To: Ministry of Children and Family Development:

13. Adopt and implement the recommendations of the Williams Lake Collaborative Local Action Team to fund local agencies like Denisiqi Services to do the following:

a) Establish specialized clinical assessments and planning for children and youth presenting to the ER in mental health crisis
b) Create a crisis response team that is mobile, trauma informed, culturally inclusive, and is resourced to provide support to youth and their family for approximately 5-7 days following the onset of a crisis
c) Create a designated youth crisis bed in Williams Lake where voluntary patients can go to support planning and prevent transfer to a designated facility.

Presiding Coroner Comment:

The jury heard that the Williams Lake Collaborative Action Team had made a number of recommendations to the Interior Health Authority regarding youth access to mental health services including cultural safety, early intervention, that treatment be trauma-informed, and that there should be Aboriginal youth beds available in their communities. A child and adolescent psychiatrist testified that treatment close to home was best for patients.

To: RCMP E Division, Commanding Officer:

14. Review the use of conducted energy weapons in the apprehension of patients under the *Mental Health Act.*

Presiding Coroner Comment:

The jury heard that the RCMP officers were trained in the use of force based the Incident Management Intervention Model and that the model was also applicable to the apprehension of persons with mental illness. An officer testified that the RCMP has gone from being the mental health agency of last resort to the mental health agency of first resort. A psychiatrist testified that Jacob did not understand his own mental state and that he had delusions or false beliefs. There was also evidence that Tasers fail approximately 20% of the time for reasons that are unknown.

15. Create a system to connect psychiatrists with RCMP members on critical incident scenes

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Presiding Coroner Comment:

The RCMP did not contact the on-call psychiatrist for assistance in this case. The on-call psychiatrist came to the hospital when a nurse alerted him to the incident but did not go to the parkade. He had never met Jacob. He testified that he would have tried to assist the RCMP as much as he could having regard for his own safety. The Officer in Charge did try to contact a crisis negotiator who worked in the Kamloops RCMP but that person did not work weekends and could not be reached. The jury appears to have felt that a psychiatrist might have been able to assist the RCMP in bringing the matter to a different conclusion.