BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2007:196:0028

An Inquest was held at Port Alberni Provincial Court, in the municipality of Port Alberni

In the Province of British Columbia, on the following dates February 19th, 20th and 21st 2008

before Beth Larcombe, Presiding Coroner,

Into the death of TOM Christopher 38 ☒ Male ☐ Female
(Last Name, First Name) (Age)

and the following findings were made:

Date and Time of Death: August 5th 2007 between 0320 and 0416 hours

Place of Death: RCMP Tofino Detachment Cell #1 (Location) Tofino, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Respiratory Arrest

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Acute alcohol intoxication

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 21st day of February AD, 2008.

BETH LARCOMBE
Presiding Coroner's Printed Name

Presiding Coroner's Signature

POSTED

TOM	Christopher
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Beth Larcombe

Coroner Counsel: Mr. John Orr

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: Ms. Helen Roberts, Counsel for the Dept. of Justice for the RCMP
Hugh Braker QC, for the family of Christopher TOM and the Tla-o-qui-aht First Nation

The Sheriff took charge of the jury and recorded 14 exhibits. 18 witnesses were duly sworn in 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 Verdict 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 verdict.

For two and a half days evidence was heard from all those involved in the investigation following the death of Christopher Tom, also known as Christopher Charlie, from here on referred to as Mr. Tom.

Mr. Tom died in Tofino on August 5th 2007, in cell number one at the Tofino RCMP detachment. He had been arrested in the early evening of August 4 2007, by two RCMP officers for being drunk in a public place. He lived on Meares Island just off the coast from Tofino, and he was a member of the Tla-o-qui-aht First Nation. Meares Island has two communities belonging to the Tla-o-qui-aht First Nation, the Esowista and Opitsaht Reserves. Mr. Tom lived in the Opitsaht Reserve.

The RCMP guard log, entered as evidence, indicated Mr. Tom had been visually checked approximately every 15 minutes by the guard looking through the cell door window. After nine hours in the cell he was discovered to be unresponsive when a guard requested an officer enter the cell to check if Mr. Tom was breathing. The first responding officer stated he used pain stimulus in an attempt to rouse Mr. Tom before deciding he was not breathing. He testified that he gave two resuscitation breaths before standing back. An ambulance was called that arrived approximately 20 minutes later and in that time no resuscitation attempts were made by the three officers now in the detachment, or the guard. All four were trained in basic first aid.

BC Ambulance crews commenced resuscitation on arrival and transported Mr. Tom to Tofino hospital where efforts continued by hospital staff for a further 15 minutes before he was pronounced dead by the emergency room physician.

The cell camera was not functioning in cell one on August 4th and 5th 2007. Cell two, which was empty when Mr. Tom was arrested, did have a working camera. The officer in charge, who was one of the two arresting officers, testified he had not remembered this when placing Mr. Tom in cell one. The jury heard that cameras are now working in both cells.

Along with those involved in the investigation, the family and those who loved him and those who considered Mr. Tom a close friend, testified to the jury about the Mr. Tom that they knew and how they will remember him. It became clear from the evidence that Mr. Tom was a quiet, non violent man, sober or not. Police and friends alike gave evidence of his respectful manner and of him being no trouble. His adult years appear to have been a pattern of binge drinking that resulted in many trips to the Tofino police cells for being drunk in a public place.

The Pathologist testified that no traumatic injury or natural disease process caused Mr. Tom's death. Two anatomical findings at autopsy confirmed previously known medical history; a very large heart consistent with someone with uncontrolled high blood pressure, and a very large fatty liver consistent with chronic heavy alcohol use.

The toxicology report from the Provincial Toxicology Centre (PTC) posed questions about Mr. Tom's potential drug use as it showed a positive level of the drug Gamma-hydroxybutyrate (GHB) also known as Rohypnol, or the 'date rape drug'. GHB was detected in Mr. Tom's blood along with a high level of alcohol. A mixed overdose of GHB and alcohol were noted as the cause of death on the autopsy report.

The Pathologist testified that the GHB requisition came at the request of a RCMP member present at the autopsy. The member had heard from a Tofino doctor's receptionist that GHB was being used in the community.

The Pathologist testified that since completing his report he had occasion to consult with the toxicologist for further explanation of the significance of the GHB. He was told GHB can be found as an artifact of post mortem changes in the human body and not because it was ingested somehow or the deceased was exposed to it. The toxicologist advised that very few studies have been done in this regard, but that levels below 50mg/L, although most studies set 30mg/L as the guide, could be attributed to a post mortem artifact. Mr. Tom had a level of 21mg/L.

The Pathologist testified that he requested further testing of the vitreous fluid to assist in determining the significance of the GHB found in Mr. Tom's blood. The PTC, however, were unable to produce results.

Throughout the inquest we heard coroner's counsel Mr. Orr explore the issue of GHB by asking all witnesses who knew Mr. Tom if they had heard of GHB use in the community, and more importantly if Mr. Tom was known to take this drug or, for that matter, any drug. Unanimous testimony stated Mr. Tom was not known to use any illicit drug, and that his drug of choice was beer.

The presiding coroner cautioned the jury as to how much weight they put on the mixed overdose of GHB and alcohol as they deliberate on the cause of death.

It is safe to say the alcohol levels found post mortem would indicate an extremely high level of alcohol in the system at the time of arrest. Mr. Tom was in cells from 1850 hours and found unresponsive at 0416 the following morning, an incarceration of more than 9 hours. Post mortem levels are recorded as 0.25% in Mr. Tom's blood. Mr. Tom's blood alcohol level when arrested may well have been at least 0.43%; a recorded lethal level. Mr. Tom's post mortem alcohol level, after being metabolized over more than 8 hours, is consistent with the post mortem vitreous level of 0.34% and the post mortem urine of 0.40%.

The Pathologist gave evidence that the mechanism of death due to the high alcohol levels would be depressed respirations. This would result over time in reduced oxygen levels to the brain eventually becoming critical levels of low oxygen. This would compromise the brain's ability to regulate body temperature and breathing. Ultimately breathing would stop, resulting in death; which the Pathologist testified is likely the mechanism in this case. The body temperature recorded at the hospital of 33.8° would indicate that Mr. Tom had been declining for some time before being discovered unresponsive; exactly how long, cannot be determined.

It is unfortunate that the exact position Mr. Tom was in when he died is not known. The images of Mr. Tom in the cell, taken by the police, show the possibility of a compromised airway. The RCMP member who entered the cell testified he rolled Mr. Tom on his back in an attempt to rouse him. When he determined he wasn't breathing, he attempted 2 breaths before stopping further CPR attempts as he felt Mr. Tom was already dead. The senior officer attended the detachment and instructed that Mr. Tom be put back onto his side as close as possible to the position he was found in, and that photographs be taken; a highly unusual step.

Given the evidence presented, it is very probable that Mr. Tom was indeed dead when the police officer went into the cell to examine him. Therefore, although the action of the officers was unusual and troubling, their assumptions and actions in this case probably did not alter the outcome for Mr. Tom.

Evidence from the guards indicated some people, like Mr. Tom, had very shallow breathing. A guard testified that they use the lines between the bricks on the wall to measure if the prisoner's torso moves up and down as an indicator if a prisoner is breathing or not. This posed the question of the guard's ability to assess prisoners like this just by visual means through the cell door window, or on a cell monitor in the guard room.

The last morning of evidence focused on services and community. A local service provider outlined the many services available in the area for drug and alcohol support. A family member and a band representative gave evidence from Mr. Tom's community's perspective.

Of the dozen or more services named, few services are available for single men and women. Statistically there are more single men in need of drug and alcohol services. This high risk population currently cannot access any residential treatment programme in this area. The jury heard that Mr. Tom could have accessed the family oriented residential programme on Meares Island if he had a family member that would go too, but he could not attend as a single man. Some residents did not want to go to this facility as it is housed in the old residential school building, and there are too many 'ghosts' for some people. The director testified the centre is relocating to Tofino sometime in 2008.

Alcoholics Anonymous visit the Island periodically and an alcohol and drug counselor arrives twice a week. Testimony indicated this is not enough for the number of residents.

The picture that developed over the course of the inquest illustrated Mr. Tom was part of a group of men, close to middle age, that drank together in Tofino and who gave and received the comfort of family and friendship to one another. They are a high risk group that appears to be under-represented in the list of service providers given in evidence.

The family and band representative spoke of the challenges living on an island accessible only by boat. They presented evidence that they would like police and physicians to let them know when a member of their

community is either in hospital or the detachment in Tofino so that they can arrange for someone to come and get them. Tofino is the nearest place to shop for people living on Meares Island. Several recommendations were posed by the family and community as a result of a meeting held on February 20, 2008 and presented to the jury for their consideration.

At the end of the evidence the Jury classified the death as accidental, and put forward the following recommendations to the Chief Coroner for dissemination.

Presiding Coroner

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO.: 2007:196:0028

TOM	Christopher
SURNAME	GIVEN NAMES

Pursuant to Section 38 of the Coroner s 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: **Commanding Officer G. Bass**
E Division RCMP
5255 Heather St.,
Vancouver, BC V5Z 1K6

1. We recommend that a buzzer and time lock mechanism be installed outside of each cell door that would ensure that a guard would physically have to attend each cell door every 15 minutes.

   Coroner's Comments: The jury heard evidence that the guards cannot enter a cell without a police officer. That it is difficult to tell if a person is breathing especially if they are known to breathe quietly with shallow breaths.

2. We recommend that Policy 19-2-1 of the RCMP E Division Operational Manual 'Assessing Prisoners Responsiveness' be adapted so that on the Rousability Chart they include "Rouse to Buzzer".

   Coroner's Comments: The jury heard evidence that the only means of rousing a prisoner if an officer is not in the building is to bang on the door or yell at the prisoner.

3. We recommend that RCMP officers receive higher training in CPR.

   Coroner's Comments: The jury heard evidence that the three officers who did not attempt CPR before the ambulance crew arrived, had only basic first aid training.

4. We recommend mandatory working cameras at all times in all cells and to have a back up camera on site.

   Coroner's Comments: The jury heard evidence that the camera in cell number one where Mr. Tom was left did not have a working camera and, therefore, he could not be observed by the guard if they were in the guard room.

To: **Commanding Officer G. Bass**
RCMP E Division
5255 Heather St.,
Vancouver, BC V5Z 1K6

Corps of Commissionaires
Vancouver Regional Headquarters
Suite 801 595 Howe Street
Vancouver, BC V6C 2T5

5. We recommend that improved communication is required between RCMP officers and Guards pertaining specifically to the C-13 forms and medical conditions.

Coroner's Comments: The jury heard evidence that the guards did not always read the C-13.

6. We recommend that RCMP officers and Guards participate in cell crisis training.

Coroner's Comments: The jury heard evidence that the guards did not receive any training for critical incidents in cells.

To: **The Nuuchahnulth Tribal Council**
President, Tom Happynook and Vice President, Michelle Corfield
5001 Mission Road
PO Box 1383
Port Alberni, BC V9Y 7M2

7. We recommend more funding for alcohol and drug prevention for the Opitsaht community.

Coroner's Comments: The jury heard evidence that the services presently available to the community of Opitsaht are inadequate for the number of people living in the community.

8. We recommend investigating other band initiatives towards an alcohol free environment such as a Detox centre in Tofino which would include more counselors.

Coroner's Comments: The jury heard evidence that the Hereditary Chiefs of the Tla-o-qui-aht First Nations had approved initiatives discussed in band council meetings to develop a safe place for their people to go where they would have shelter and support instead of going to jail. This approval is a powerful incentive to the community.

To: **The Nuuchahnulth Tribal Council**
President, Tom Happynook and Vice President, Michelle Corfield
5001 Mission Road
PO Box 1383
Port Alberni, BC V9Y 7M2

Mayor John Fraser
Municipality of the Village of Tofino
PO Box 9
Tofino, BC V0R 2Z0

Mayor Dianne St. Jacques
District of Ucluelet
P.O. Box 999
Ucluelet, BC V0R 3A0

9. We recommend funding for a Native Friendship Centre or Safe House in Tofino accompanied with drug and alcohol counselors.

Coroner's Comments: The jury heard evidence that the Hereditary Chiefs of the Tla-o-qui-aht First Nations had approved initiatives discussed in band council meetings to develop a safe place for their people to go where they would have shelter and support instead of going to jail. This approval is a powerful incentive to the community.

10. We recommend all communities in the surrounding areas support the new proposed sports facility to ensure the young generations have something to look forward to.

Coroner's Comments: The jury heard evidence that there is an active plan to build such a facility between Tofino and Ucluelet that would for example house an ice rink, gym, games room, and meeting room. A facility for all, especially the youth, in and around both communities; built by contributions from all communities.