BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

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

FILE NO.: 2008:177:0010

COON	Debra Marie
SURNAME	GIVEN NAMES

File No.: 2008:177:0010

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

in the Province of British Columbia, on the following dates June 29, 30 and July 2,3, 2009

before Jeff Dolan, Presiding Coroner,

into the death of Debra Marie COON (Last Name, First Name) 48 (Age) ☐ Male ☒ Female

and the following findings were made:

Medical Cause of Death

(1) Immediate Cause of Death: a) Acute Subdural Hematoma

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Blunt Force Head Injury

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:

Date and Time of Death: March 14, 2008 22:12

Place of Death: Victoria General Hospital (Location) Victoria, BC (Municipality/Province)

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

The above verdict certified by the Jury on the 3rd day of July AD, 2009.

JEFF DOLAN

Presiding Coroner's Printed Name

POSTED

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Jeff Dolan

Coroner Counsel: Mr. John Orr

Court Reporting/Recording Agency: Ms. Patricia Jane

Participants/Counsel: Vancouver Island Health Authority, represented by Ms. Leslie Slater
British Columbia Ambulance Service, represented by Mr. Ian Wiebe
Royal Canadian Mounted Police, represented by Mr. David Kwan

The Sheriff took charge of the jury and recorded three exhibits. 23 witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided 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.

The cousin of Debra Coon described her as a loving and compassionate woman. Ms. Coon struggled with addictions from a young age. Despite numerous attempts at sobriety and treatment, her struggle continued until the day she died; March 14, 2008 at the age of 48.

The jury heard that Ms. Coon and her husband reportedly began consuming sherry at their Port Hardy residence at approximately 1000 hrs on March 13th, 2008. In the early morning hours of March 14th, Ms. Coon began to behave in a bizarre manner; hallucinating and speaking with people who were not there. After she collapsed at 0255 hours, her husband called 911 for assistance.

BC Ambulance Service (BCAS) paramedics arrived and attended to Ms. Coon. She appeared to be hallucinating, was unsteady on her feet and had an odour of liquor about her. All signs appeared to be indicative of an individual intoxicated by alcohol. Ms. Coon had also commented to the paramedics that she had recently used cocaine. Emergency responders reported no evidence of injury upon examination. Ms. Coon was transported to the Port Hardy Hospital (PHH) Emergency Room (ER) by ambulance.

In the ER, Ms. Coon was unable to answer questions directly and had tangential thoughts. When asked, Ms. Coon denied any history of mental health issues and denied any suicidal or homicidal ideation. The ER physician did not have the authority to detain her under the *Mental Health Act.*

The jury heard that a person may be detained under the *Mental Health Act* if they are a danger to themselves or others. The assessment and signature of only one physician is required to detain a person for 24 hours. Any detention beyond that requires the assessment and signature of a second physician

The observations of the emergency room physician were also stated to be consistent with intoxication by drugs or alcohol and there was no outward evidence of injury.

There was no available ER staff to observe Ms. Coon on the morning of March 14. Concerned that Ms. Coon was unable to care for herself, the ER physician contacted the Port Hardy RCMP Detachment to request that she be kept at their detachment for the night and released in the morning. The physician advised police that the patient was not suicidal and was 'fit for cells'. If allowed to leave the hospital on alone, Ms. Coon was at risk of remaining outside, exposed to the elements.

Ms. Coon was taken into custody by a member of the Port Hardy RCMP. She was to be held in custody for her own safety and released when sober.

Ms. Coon was lodged into cells at 0433 hours. The prisoner report notes that no injuries were observed and the prisoner was "fumbling" and "falling"; her "speech was slurred"; her state of mind was "normal" and her level of consciousness was described as "alert". She was not designated on the report as having mental health issues.

At approximately 0609 hrs Ms. Coon was observed on the cell monitor to fall on her backside, get up and fall against one of the concrete benches. She did not strike her head. Officers attended the cell and Ms. Coon made no complaint of pain or injury.

Ms. Coon was observed to fall again at 0818 hrs. Officers attended and determined that she had not sustained any injuries.

Two more falls were recorded on the cell video at 0844 hrs and 0857 hrs. The falls were not observed or documented in the log book by the matron who was occupied with other duties in the cell area. At 0857 hrs Ms. Coon was observed on the video to fall and strike her head.

Ms. Coon was observed by the matron to fall and strike her head at 0915 and an officer was called to attend the cell. Four minutes later the prisoner was observed to fall and strike her head again. The attending officer was informed of the apparent head strike and he requested that BCAS be called.

BCAS initial assessment of Ms. Coon revealed no evidence of head or neck injury and Ms. Coon did not complain of any pain as a result of the falls. A hands-on examination of the patient was not conducted and she was transported by ambulance to the emergency room two minutes away.

The emergency room physician was not informed of the falls in police cells when treating Ms. Coon for the second time. As a result, no x-ray or computed tomography (CT) scan was considered. Vitals were all normal at 1008 hrs and there continued to be an impression of substance abuse with psychosis as secondary.

The PHH ER was busy on the morning of March 14th. The facility was over capacity with 12 beds for 14 patients.

The Manager of Mental Health and Addictions for the Vancouver Island Health Authority, North Island had known Ms. Coon for 5 years due to her addictions and time spent in hospital for detoxification. He knew her to have bad withdrawal phenomena and had witnessed her experience the DT's.

The Manager saw Ms. Coon on March 14th in the PHH nursing station. He voiced his concern regarding acute withdrawal, which can lead to DT's and seizure. He could not smell liquor on Ms. Coon and would not have expected to days into her withdrawal. He was assured that a doctor had been notified and Ms. Coon was assisted into what he described as the 'semi-observation' room near the nursing station.

After her initial examination by the physician, Ms. Coon departed the ER. Moments later a mental health worker located Ms. Coon seated in a puddle at edge of PHH ED parking lot. Ms. Coon was returned to the ER and provided with warm dry clothing and blankets. A nurse examined Ms. Coon and observed a bump in the occipital area of her head with some associated bleeding and an abrasion around her right eye. Ms. Coon was placed in the observation room adjacent to the nursing station.

A PHH care aide observed Ms. Coon via the black and white video monitor while she was in the observation room. Ms. Coon was pacing around the room and was on and off the bed for approximately ten minutes. The care aide looked away for a moment and, when she looked back, the patient was no longer visible on camera. Ms. Coon was found unresponsive on the floor, appearing to have a seizure. Treatment was initiated and a code was called. Ms. Coon was intubated with difficulty and ventilated by hand due to the fact that the ventilation machine was not working.

Examination revealed unequal pupils indicative of an intracranial bleed. Victoria General Hospital (VGH) neurosurgery was consulted and arrangements were made for transport by air ambulance to Victoria.

The VGH ER physician was informed that one or more falls had occurred in Port Hardy, resulting in head injury and loss of consciousness. A neurological exam and a CT scan revealed a large subdural hematoma and subarachnoid bleed due to injuries sustained in the preceding 48 hours. As a result of the injury, there was no circulation to her brain. A neurosurgical consult concluded there was no hope for recovery and intervention was suspended. Palliative care was withdrawn in consultation with family members and death was pronounced at 2212 hours March 14, 2008.

A post-mortem examination confirmed the death of Ms. Coon was due to an acute subdural hematoma due to blunt force head injury. The forensic pathologist was unable to determine which external injury caused the death. The duration of the bleed could also not be determined; however the injuries were very recent. The force required to cause injuries of this nature would depend on the health of the individual.

The results of toxicological examination of post-mortem blood and urine were negative for alcohol and cocaine. Medications present in the blood were within therapeutic levels and determined to have been administered during the course of medical therapy on March 14th.

Examination of the liver revealed fatty change and areas of necrosis; consistent with someone who consumed alcohol excessively on a regular basis.

On the afternoon of Friday March 14th, Ms. Coon's family learned that she had suffered seizures at the Port Hardy Hospital and was transported to Victoria by air ambulance.

Ms. Coon had spoken with her sister many times by phone on March 13th; the final time being 2145 hrs. Her sister testified that she could tell Ms. Coon had not been drinking on March 13th.

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In preparation for travel to a planned family event on March 14th, it is believed that Ms. Coon stopped drinking as early as noon on March 12th. It was recommended to Ms. Coon by her sister that she visit her physician for a valium prescription. Ms. Coon was known to experience the delirium tremens (DT's) when withdrawing from alcohol.

Ms. Coon's family physician of many years testified that she had a documented addiction to alcohol and had been into the Port McNeill hospital numerous times for detoxification.

Her physician described alcohol withdrawal in the form of delirium tremens or (DT's). Symptoms include the patient being jittery, disoriented, confused and paranoid. The patient may experience hallucinations and may scratch at him or herself believing there are bugs crawling on him or her. The DT's can begin on day two or three of withdrawal and last several days depending on the health of the individual.

Her physician knew Ms. Coon to experience some of these symptoms in the past, for which she was prescribed sedatives such as valium. He testified that the behaviour exhibited by Ms. Coon on March 14th may be indicative of non-drinking as of March 13th.

During his testimony, the Staff Sergeant in charge of the Port Hardy RCMP detachment provided a comparison of Port Hardy and Port McNeill. Port Hardy has a population of 5000 while Port McNeill has a population 2600. Port Hardy RCMP conducts approximately 5000 investigations each year, resulting in 1000 prisoners; 50-60% of which are alcohol of drug related. By comparison, Port McNeill RCMP conducts 1400 investigations per year resulting in 100 prisoners.

The Staff Sergeant described the substance abuse and addiction problem in Port Hardy as being not a criminal or medical problem, but a social problem.

In her evidence, a representative of the Port Hardy branch of the Salvation Army spoke of the Lighthouse Resource Centre. The resource centre is staffed by a crisis nurse, psychiatric nurse and nurse practitioner during lunch and evening hours. The approach of the centre is considered to be proactive; providing people with services at their point of need. The program is a success due to the cooperation of the RCMP.

Those in need of shelter only stay overnight from October to March. Cold weather shelters are restricted to non-combative individuals and are open for 12 hours/day depending on the weather. There is no trained staff at the shelter and it is not a sobering centre.

The Salvation Army representative called for the community and officials to become active with more than a public awareness campaign. In Port Hardy there is a need for housing and a safe place to place people like Debra Coon.

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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: Howard Waldner
Chief Executive Officer
Vancouver Island Health Authority
1952 Bay Street
Victoria, BC V8R 1J8

1. Provide blood alcohol testing equipment to better assist in the assessment of patients for treatment at Port Hardy Hospital.

Coroner's comments: The Nurse Lead for the Port Hardy Hospital described Port Hardy as a small community with limited services. A blood alcohol monitoring machine would assist medical staff with the diagnosis of patients. Currently the closest machine is in Port McNeill.

2. Increased ER training for doctors and nurses in rural areas

Coroner's Comments: In his evidence, the Victoria General Hospital Emergency Physician commented that Ms. Coon's diagnosis and treatment would have benefited from the resources of a larger facility. The VGH ED recommended course of examination and diagnosis of a suspected head injury differed from the actions taken at the PHH ED on March 14th.

3. Refit observation room in Port Hardy Hospital to ensure safe observation of patients who are mentally ill or intoxicated

4. Provide trained staff for observation room in Port Hardy Hospital

Coroner's Comments: The Manager of Mental Health and Addictions for the Vancouver Island Health Authority, North Island, testified that the PHH 'semi-observation room' is not properly equipped. The video monitoring system is not adequate, the medical gases are not secure, and the bathroom contains hazards and is out of sight of the camera. The room is not suitable for someone with a mental disorder. In addition there are no security guards at PHH.

To: Sue Conroy
Chief Operating Officer
BC Ambulance Service
PO Box 9600
Victoria, BC

5. Policy Recommendation: Ambulance attendant to consult with matron/ guard prior to transporting injured prisoners to hospital

Coroner's Comments: The BCAS Emergency Responders who attended the Port Hardy RCMP cells on March 14th spoke only with the officers and not the matron who had been observing Ms. Coon for several hours.

To: Mayor Bev Parnham
District of Port Hardy
PO Box 68
Port Hardy, BC

Chief Verna Hunt
Fort Rupert Band
British Columbia

Chief Tom Nelson
Quatsino Band
British Columbia

Chief Paddy Walkus
Gwa'sala-Nakwaxda'xw Band
British Columbia

6. That public awareness programs be developed and delivered to highlight social issues within the District of Port Hardy.

To: Honourable Chuck Strahl
Indian and Northern Affairs Canada
Ottawa, Ontario
K1A 0H4

The Honourable Leona Aglukkaq, P.C., M.P.
Health Canada
Brooke Claxton Building, Tunney's Pasture
Postal Locator: 0906C
Ottawa, Ontario K1A 0K9

Honourable Kevin Falcon
Ministry of Health Services
1515 Blanshard Street
Victoria, BC V8W 3C8

Mayor Bev Parnham
District of Port Hardy
PO Box 68
Port Hardy, BC

Salvation Army
British Columbia Divisional Headquarters
103 - 3833 Henning Dr
Burnaby BC V5C 6N5

7. To initiate plans for the development of a sobering centre, detoxification centre, 'pre' and 'post' treatment safe house and treatment facilities in Port Hardy

Coroner's Comments: A number of witnesses testified that it is the responsibility of the community to acknowledge and address the addiction problems in Northern Vancouver Island. There must be intervention by Aboriginal Elders and Chiefs as well local, provincial and federal government, emergency services and community members.

Ms. Coon's family physician recommended a contained system be created; consisting of a vertical integrated treatment system in the North Island capable of providing post detoxification resources ranging from day to residential treatment. When detoxifying, an individual must be treated medically, provided with counseling and access to an appropriate residential treatment centre. Individuals must be able to get out and stay out of their current situation.

In situations such as Ms. Coon's, police could bring those in need to the type of facility described, rather than police cells.