BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

An Inquest was held at The Courthouse, in the municipality of Cranbrook

in the Province of British Columbia, on the following dates October 9th and 10th, 2012

before T.E. Chico Newell, Presiding Coroner,

into the death of KOHALYK, Collan Michael (Last Name, First Name, Middle Name) 36 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: January 3, 2011 @ 16:55 hours

Place of Death: Kelowna General Hospital (Location) Kelowna, British Columbia (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) Hanging

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 10th day of October AD, 2012.

T.E. Chico Newell
Presiding Coroner's Printed Name

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT INQUEST

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

KOHALYK	Collan Michael
Surname	Given Names

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: T.E. Chico Newell

Coroner Counsel: Roderick H. Mackenzie

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: The Attorney General of Canada/David Kwan
The City of Cranbrook/Michael McAllister

The Sheriff took charge of the jury and recorded 4 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.

On December 24, 2010 at approximately 12:30am RCMP members were dispatched via 9-1-1 to attend an apparent domestic dispute in an apartment building within the municipality of Cranbrook. There they located a male in the midst of a physical altercation with a female. The male, identified as 36 year-old Collan Michael Kohalyk, was arrested and taken to the local jail. Mr. Kohalyk was described as combative and resistant. The female was taken to the local hospital and treated for non-life threatening injuries. The two had spent the afternoon and into the evening at a number of local establishments consuming alcohol.

Mr. Kohalyk was uncooperative when being 'booked-in' at the jail. The officers had to physically restrain him en route to the cell. He was placed face down on the cell floor. The handcuffs and his jacket were then removed. The officers quickly exited and secured the cell door so as to avoid further physical conflict. The Guard's book recorded Mr. Kohalyk being placed into Cell 1 at 1:00am. The jail policy allowed prisoners one layer of clothing. Any clothing later removed by the prisoner was to be combined with the previously obtained clothing/personal effects. Mr. Kohalyk was placed in the cell with a sweater and a t-shirt along with blue jeans and socks. Mr. Kohalyk removed his sweater and refused to pass it out of the cell. A decision was made not to enter the cell to obtain the sweater as doing so was foreseen to escalate the situation with Mr. Kohalyk and would have resulted in injury. By closed

circuit television (CCTV), the guard observed Mr. Kohalyk remove his t-shirt and his pants. At 1:14am the guard observed and recorded he was standing. The CCTV image did not capture the entire cell.

Mr. Kohalyk placed his t-shirt around a cell wall bar above a cross piece and with his back to the wall tied the t-shirt tightly around his neck. He lowered his body adding tension to the t-shirt restricting blood flow and oxygen to his brain. At 1:28am via CCTV the guard noted Mr. Kohalyk standing in an area of the cell commonly used as the best vantage point for a prisoner. At 1:29am the guard directly observed Mr. Kohalyk to be, in fact, hanging in the same location. The guard called for assistance, entered the cell and lifted Mr. Kohalyk while an officer cut the t-shirt material. He was lowered to the ground and placed on his back. No pulse was found and cardiopulmonary resuscitation was undertaken. Firefighters and then paramedics arrived and attended to Mr. Kohalyk. A pulse was established and shallow breathing noted. He was transported to the Emergency Department at East Kootenay Regional Hospital.

The initial assessment was undertaken by the Emergency Physician at 2:10am. A rapid sequence intubation was completed. Mr. Kohalyk was found to be unconscious and in severe respiratory distress. He was ventilated. Laboratory testing revealed ethyl alcohol in the blood. Urinalysis screening detected methadone and opioids in the urine. As there was no means to complete a neurological assessment locally, Mr. Kohalyk was transferred from East Kootenay Regional Hospital on December 24, 2010 at 10:53am via air ambulance arriving at Kelowna General Hospital at 12:30pm. He was medically maintained. Neurological assessment revealed significant permanent anoxic brain injury. On December 30, 2010 at 9:12pm there was a decision to move to comfort measures only. Mr. Kohalyk passed away with family at his side on January 3, 2011 at 4:55pm.

An autopsy was performed which revealed the cause of Mr. Kohalyk's death was an anoxic brain injury sustained as a result of hanging. The pathologist would have ideally ordered toxicology study be done on the blood/urine specimens that were collected when Mr. Kohalyk was admitted to hospital ('admission specimens'). This would have identified the drugs in Mr. Kohalyk's system and allowed the pathologist to give an opinion of his relative state of impairment/intoxication. Those 'admission specimens' were however discarded per hospital policy prior to the death. This created a deficit in the totality of the potential post mortem findings.

The jail cells at the Cranbrook RCMP Detachment were under a national retrofit directive and work was being done towards completing changes that would make the cells safer. At the time of Mr. Kohalyk's arrest, the retrofit of those cells was not complete. Mr. Kohalyk was placed into an available older style of cell. The initial phase of the retrofit was completed and a policy revision was subsequently completed (dated: 2011-11-15) directing to use the retrofitted cells first and to 'double-bunk' in the old cells unless there is a safety issue. The completion of the remaining retrofit of cells is the subject of a five year capital plan. At the time of the Inquest, the cell in question had not been retrofitted.

Mr. Kohalyk was the healthy, happy child of proud parents. Into his adult years he became a loving father. Life became more challenging for him with personal matters. At times he was consumed with significant mental health challenges, personal problems and a complex of consequential issues. Such was the case at the time of his death.

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

KOHALYK	Collan Michael
Surname	Given Names

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: Commander, "E" Division, RCMP

Having reviewed the changes to the Prisoners-Cell Block Operations Manual dated 2011-11-15 we recommend the following:

When circumstances require a prisoner be placed in the Cranbrook Detachment's old un-retrofitted cells then members or guard shall ensure that all discarded clothing be removed from the cells immediately.

Coroner's Comments: The jury heard evidence that significant retrofitting of five old cells had been completed, closed circuit television system had been improved and policy had been revised and adapted relating to the retrofitted and the existing old style cells. The practice involved discretion on the part of the guard/officer in the decision to obtain removed clothing which was based largely on the matter of safety and relative risk of escalation and injury. It was recognized that any item of clothing, once removed, had the potential to create harm in the old un-retrofitted cells.

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JURY RECOMMENDATIONS:

To: Minister of Health

We recommend to the Minister of Health that all hospital and health care facility admission samples obtained from individuals associated to apparent or suspected unnatural circumstance (for example: motor vehicle incidents, police custody, suicide attempt, homicide, etc.) and when that person is admitted to a hospital's Intensive Care Unit with a critical prognosis, those specimens will be held frozen for the Coroner for a period of not less than 30 days.

Coroner's Comments: The jury heard evidence that the 'admission specimens' of blood and urine were discarded according to hospital laboratory policy in the interval preceding Mr. Kohalyk's death. The non-availability of these specimens precluded the pathologist from completing specific toxicology testing. This, therefore, limited the information that could be compiled by the pathologist regarding the identification of drugs in Mr. Kohalyk's system, his relative state of impairment/intoxication at the time of the admission to hospital and ultimately, the possible contributory role impairment/intoxication may have played in his death.
The recommendation describes at the time of usual hospital disposal of 'admission specimens' that those specimens be retained frozen for a 30 day retention period for the benefit of subsequent medico-legal investigation.