BRITISH COLUMBIA

Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2013:0380:0003

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

SURNAME	GIVEN NAMES
GEORGE aka OLEKSIUK	**ALYSSA JOSEPHINE TALINA**

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

in the Province of British Columbia, on the following dates October 19, 20, 21, 2015

before: Donita Kuzma, Presiding Coroner.

into the death of George aka Oleksiuk (Last Name) Alyssa Josephine Talina (First Name) (Middle Name) 25 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: September 10, 2013 2045 hours

Place of Death: 855 W 12th Avenue Vancouver General Hospital (Location) Vancouver, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multiple organ and system failure

Due to or as a consequence of

Antecedent Cause if any: b) Metabolic acidosis and respiratory depression

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Acute and prolonged ETOH and substance abuse

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 21 day of October AD, 2015

Donita Kuzma
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Donita Kuzma
Inquest Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Helga Sievewright, Verbatim Words West Ltd.
Participants/Counsel:	Attorney General of Canada, David Kwan

The Sheriff took charge of the jury and recorded 7 exhibits. 18 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.

The jury heard evidence that Alyssa Josephine Talina George, also known as Alyssa Oleksiuk, was a 25 year old woman who had a long history of alcoholism and substance abuse. In the months prior to her death, she experienced ongoing nausea and vomiting related to her continued frequent use of alcohol.

On the morning of September 3, 2013, RCMP in Terrace responded to a complaint from a landlord over the eviction of his tenant, Alyssa George (Oleksiuk). At approximately 1030 hours, two RCMP officers arrived at the residence where Alyssa was located and found her in an upstairs bedroom. She was under the covers on a bed and identified herself to the officers. The officers were aware there was an unendorsed warrant for Alyssa so they took her into custody. Before she left the residence, Alyssa informed one officer that she had been drinking alcohol but, she did not say when she had stopped drinking, nor did the officer ask. She was observed to be steady on her feet and had an odor of 'alcohol' to her breath. Alyssa was assisted into an RCMP squad car and transported to the City of Terrace jail cells.

The "C13" Prisoner Report is an RCMP document that is completed each time a person is lodged into RCMP cells. The arresting officer is primarily responsible for completing the form; however, some information will carry over from previous bookings. The C13 report for Alyssa indicated that she was booked into cells at 1142 hours on September 3. In the "prisoner screening" section of the C13 form, the possible cause of impairment was noted to be alcohol. The box for "responsiveness checked" was ticked. Her speech was noted to be slurred; her balance as fair, her state of mind as placid and her consciousness as sleepy. A video recording (with sound) of the interactions at the booking desk was shown to the jury. The acting RCMP Watch Commander told the jury Alyssa appeared too intoxicated to take before a judge and she was lodged into cell 8. In the cell were a bench and toilet; also a pillow, blanket and some

magazines. Severely intoxicated females were usually held in cell 7, where there are no amenities other than a toilet. The cell video camera recording (with no sound) showed that once Alyssa was in the cell, she laid down on the bench. Alyssa was provided a meal at approximately 1700 hours (5 pm), but video recordings revealed she did not eat anything from the tray. Alyssa's spouse was already in cells when she arrived. The jury heard evidence her spouse told the guards that Alyssa was sick.

In each of the nine cells in the Terrace RCMP cell block, there was a closed circuit video camera with a live feed that can be watched at the cell block desk. At the desk, there was a bank of high definition screens. Video from each cell appeared in a frame that is approximately 6 inches by 6 inches on the screens, in colour. The video from the cameras was recorded. The camera does not transmit or record sounds from the cells. A video recording for the time Alyssa booked in at the desk and for the entire time she was in cells was admitted into evidence.

The guards who work in the RCMP cells blocks are employees of the City of Terrace. They are supervised by a City employee, but receive direction from the RCMP officers on shift and are to follow RCMP policy. The cells have one guard on duty at a time and the shifts are 12 hours in length. If there are twelve or more prisoners in cells, a second guard is called in to work. Terrace RCMP policy on prisoner care is that guards are not to enter the cells without an officer.

The jury heard that on the evening of September 3 and into the early morning of September 4, Alyssa spent a great deal of the time sitting or lying on the mattress in the cell. Terrace RCMP policy on prisoner care is that prisoners in cells are to be physically observed from the door every 15 minutes. The videos showed that between 1200 hours on September 3 and 0220 hours on September 4, guards came to the window of her cell 14 times. The guards told the jury they are better able to assess the condition of persons in cells when viewing the video screen at the desk than when they look into the cell via the window on the door.

An RCMP Inspector testified Terrace RCMP Operational Policy is that RCMP shift supervisors (watch commander) are to check on all prisoners at the beginning and end of each shift. The shift supervisor (watch commander) is also to check on the prisoners not less than every four hours throughout the shift and these checks are to be noted in the prisoner log book. RCMP policy indicates video checks are not to take the place of physical checks. Under ideal circumstances, it is best to do a rousibility test. If a prisoner's condition does not improve in 12 hours, the officers and guards should consider having the prisoner medically assessed. The Inspector told the jury that about 1600 prisoners are brought into Terrace cells each year and of those, 70 to 80 % are arrested for public intoxication.
The night shift guard testified that he became concerned about Alyssa when he checked at her at 0220 hours, and requested that an RCMP officer enter the cell to check on her. At 0227 hours,

two officers entered the cell, observed Alyssa, but did not check for a pulse. The officers then left and did not return to the cell until 0232 hours, at which time Alyssa was rolled into the recovery position. One officer then stayed with Alyssa while the Corporal went back to the desk and called for an ambulance.

Two BC Ambulance paramedics arrived to Alyssa's cell at 0235 hours. The jury heard that when they arrived, Alyssa did not have a pulse that could be felt in her wrist and her blood pressure was extremely low. She also was found to have a decreased level of consciousness. They transported her to Mills Memorial Hospital and arrived there at 0245 hours. Alyssa's blood pressure was found to be 83/17. She was admitted to the emergency room (ER) and attempts were made to start an intravenous. Her blood sugar was found to be extremely low and she was given Glucagon. One of the attending ER doctors told the jury that Alyssa was displaying symptoms of shock when she was admitted. She was also jaundiced; this is a condition when the liver is failing and the skin turns yellow in colour. At 0434 hours, Alyssa went into cardiac arrest and cardiopulmonary resuscitation (CPR) was started. Her heart rhythm was re-established and she was admitted to the Intensive Care Unit (ICU) on full life support.

Alyssa's condition continued to deteriorate. She was transported via air ambulance to the Vancouver General Hospital (VGH) and admitted to the ICU. The critical care physician who attended to Alyssa at VGH told the jury that when admitted, Alyssa had organ failure, brain damage and her prognosis was very poor. She was also found to have severe lung injury from an aspiration of stomach fluids. Her care was taken over by another ICU doctor and he told the jury that Alyssa did not respond to aggressive medical treatment and all her organs continued to fail. At 2045 hours on September 10, she was removed from life support and death was pronounced.

A forensic pathologist testified that he conducted a full post mortem examination on September 13, 2013 at VGH. The pathologist said that the autopsy findings showed Alyssa died as the result of multi organ system failure.

Blood samples that were collected from Alyssa at 0720 hours on September 4 at the Mills Memorial Hospital were sent to the Provincial Toxicology Centre of British Columbia for analysis. The toxicologist told the jury that testing on this blood revealed the presence of benzoylecgonine, the metabolite of cocaine, at a level that indicated Alyssa had used cocaine at some time fairly recently.

A doctor with the BC Coroners Service Medical Unit, who reviewed Alyssa's medical records and watched the cell videos, was called as a witness to the inquest. He found that Alyssa had been quite ill from her ongoing alcohol (ETOH) abuse and had severe liver disease. He explained to the jury that the liver is involved in the metabolism of glucose and stores glucose in

the form of glycogen. When someone does not eat, or has a poor nutritional intake, as Alyssa did in the months leading up to her death, the body will take glycogen from the liver to use for energy. When the glycogen stores are used up, the body still needs energy and will start to burn fat. The by-products of this create "ketone bodies" causing the body to become more acidic, leading to a condition called metabolic ketoacidosis. Intake of alcohol also impairs the breakdown of glycogen by the liver. Alyssa was also experiencing respiratory depression and the reduced level of oxygen also contributed to acidosis. The doctor told the jury that prolonged acidosis leads to multi organ failure.

The doctor testified to what he saw when he viewed the videotapes of Alyssa in her cell. At 2142 hours on September 3, Alyssa was showing signs of being very ill and in medical distress; however, he said a non-medically trained person would not have recognized this. He told the jury that in his opinion Alyssa died of multi organ failure due to metabolic acidosis and respiratory depression resulting from acute and chronic ethanol (alcohol) abuse.

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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: RCMP (*the Commissioner)*

1. The RCMP C13 form requires additional space for initial medical info/questioning/survey/screening, such as

   A. When was last intake of alcohol or drug
   B. Taking any medication/what?/Dosage
   C. Pre-existing medical condition?
   D. Allergies

Presiding Coroner Comment: *The jury saw that the C13 form was missing information.*

To: RCMP (*the Commissioner*)

2. Consider all policies/procedures and standards as mandatory, not best practices.

Presiding Coroner Comment: *The jury heard evidence that the RCMP were not following their prisoner care policy.*

To: RCMP (*Terrace Detachment*)

3. Ensure RCMP watch commander performs and is accountable for physical (in cell) checks every 4 hours of all prisoners in cells.

Presiding Coroner Comment: *The jury heard evidence that the watch commanders did not routinely check the cells every 4 hours.*

To: RCMP (*Terrace Detachment*) and City of Terrace

4. Guards must follow/adhere to existing policies/procedure (operation manual part 19) concentrating on: 4 R's (Rousibility), watch command 4 hour prisoner check, guard physical check every 15 min.

Presiding Coroner Comment: *The jury heard that the guards were not conducting physical checks every 15 minutes.*

To: RCMP (*Terrace Detachment*) and City of Terrace

5. Use of CCTV should be used as a secondary backup to physical checks.

Presiding Coroner Comment: *The jury heard evidence that the guards and the RCMP officers were using the CCTV as the primary way to check on prisoners and physical checks at the door were not occurring every 15 minutes as policy stated.*

To: RCMP (*Terrace Detachment*) and City of Terrace

6. RCMP/Guards should use the cell check log appropriately (follow all blocks of the form and fill out completely).

Presiding Coroner Comment: *The jury saw evidence that the cell check records were not being filled out properly.*

To: RCMP *(Terrace Detachment)* and City of Terrace

7. To assist the guards doing the physical cell checks, the hall lighting could be reduced or a matte coating on cell door window to reduce the glare from the above lights.

Presiding Coroner Comment: *The jury heard testimony that at times it is difficult to see into the cells.*

To: RCMP (*the Commissioner*) and City of Terrace

8. Consider reducing OM 19.2, section 2.1.2.6 to reduce medical assessment time to 8 hours.

Presiding Coroner Comment: *The jury heard evidence that Alyssa was in medical distress after being in cells for 9 hours, 45 minutes and policy is to seek medical assessment if the prisoner's condition does not improve in 12 hours.*

To: RCMP (*Terrace Detachment*) and City of Terrace

9. A committee should be established to discuss the possibility and funding a second guard on duty at all times.

Presiding Coroner Comment: *The jury heard evidence that a second guard is not called in to work unless there are 12 prisoners in the cells.*

To: RCMP (*Terrace Detachment*) and City of Terrace

10. Investigate upgrading the existing CCTV system to include larger monitors, with the ability to select the video feed to focus on one cell, ability to zoom and pan video feed while maintaining the source feed for the recording, audio mics at each end of the hallways free of background noise.

Presiding Coroner Comment: *The jury saw video and heard audio recordings of such a quality that led them to believe the entire CCTV system and it capabilities could be improved and upgraded.*

To: RCMP (*Terrace Detachment*) and City of Terrace

11. Install a 2 way non-recording intercom system into all cells, other than 1 & 7, for rousability checks, a loud buzzer noise in cell to precede actual 2 way communication for prisoner privacy.

Presiding Coroner Comment: *The jury heard evidence that cell cameras transmit video only to the viewing screen at the cell block desk.*

To: RCMP (*Terrace Detachment*) and City of Terrace

12. Ensure that all guards and RCMP members take the existing training as required and investigate increasing some training cycles to ensure retention of information/policies/procedures.

Presiding Coroner Comment: *The jury heard evidence that this was not occurring on a regular basis.*

To: RCMP (*the Commissioner*) and City of Terrace

13. First aid training should be enhanced to include medical information and scenario training more conducive to alcohol and drug addiction, and community level training such as the intergenerational effects of residential school on First Nations, as well as the cultural sensitivities of other minorities.

Presiding Coroner Comment: *Alyssa was a woman of First Nations descent. The jury heard that guard and RCMP training does not provide in-depth education on such topics as alcohol and drug addiction, the intergenerational effects of residential schools on First Nations and cultural sensitivity.*

To: Provincial Ministry of Health

14. Must keep blood samples taken from patients who are gravely ill for 14 days for testing and follow patient if transporting to alternative medical facilities.

Presiding Coroner Comment: *The jury heard that the blood collected from Alyssa at the time she was admitted was discarded and not available for toxicology testing.*

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To: Northern Health, First Nation Health Authority, Ministry of Health, and City of Terrace

15. A committee/focus group should be established to investigate the construction of a proper medically staffed substance abuse/detox center in the City of Terrace to service all outlying areas. This should include one or more substance abuse doctor and counsellor.

Presiding Coroner Comment: *The jury heard from a local doctor that Alyssa had asked for assistance for her drug and alcohol addiction, but there is no detoxification treatment unit located in Terrace; the closest is in Prince George.*

To: Ministry of Health, Northern Health, RCMP, Mills Memorial Hospital, and BC Ambulance Service

16. Investigate having a better and more accurate means of transmitting urgent/non-confidential medical information from one agency to another.

Presiding Coroner Comment: *The jury heard that there is limited communication between agencies of a prisoner's health problems.*