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

File Number: 2016-1030-0071

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	**JOCELYN NYNAH MARSHA**

An Inquest was held at Capitol Theatre, in the municipality of Port Alberni

in the Province of British Columbia, on the following dates: June 21, 22, 23, 24, 25, 28, 29, and 30, 2021

before: Margaret Janzen, Presiding Coroner.

into the death of George, (Last Name) Jocelyn Nynah Marsha (First Name, Middle Name) 18 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: June 24, 2016 (Date) 1920 hours (time)

Place of Death: Royal Jubilee Hospital (Location) Victoria, British Columbia (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Drug induced myocarditis

Due to or as a consequence of

Antecedent Cause if any: b) Toxic effects of methamphetamine and cocaine

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 30 day of June AD, 2021

Margaret Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

Province of British Columbia

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	John Orr, QC
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mark E. W. East and Boris Kozulin, counsel for the Attorney General of Canada, representing the interests of the Royal Canadian Mounted Police
	Adam Howden-Duke and Ruth Nieuwenhuis, Counsel for BC Emergency Health Services
	Reece Harding, counsel for the City of Port Alberni

The Sheriff took charge of the jury and recorded **20** 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

Jocelyn Nyna Marsha George was an eighteen-year-old Indigenous girl who resided in Port Alberni. She was a dancer, enjoyed baking for her family, and had two children who were living with her mother. Her extended family lived in the area and were involved in her life.

On June 9, 2016, at approximately 0550 hours Jocelyn was arrested following a report that she had knocked on a resident's door and said someone was trying to shoot her. She had been released from custody at the detachment approximately one hour prior to that. RCMP attended and found her to be delusional and unable to care for herself. They arrested her under the *Liquor Control and Licensing Act* for being intoxicated in a public place, given the lack of alternatives to provide for her safety. She was examined at the detachment by paramedics who found she had tachycardia (an elevated heart rate), paranoia, and delusions. They felt she was experiencing toxic effects from drug use so transported her to the West Coast General Hospital by ambulance. She was initially diagnosed with polysubstance-induced psychosis and was committed under the *Mental Health Act.* She was treated and then released on June 13, 2016, with a final diagnosis of methamphetamine intoxication and alcohol withdrawal. She was to follow up with a drug and alcohol counsellor at the Friendship Centre and her family physician. She had no signs of cardiac issues at that time.

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On June 23rd, 2016, at approximately 0700 hours a concerned citizen reported to RCMP that Jocelyn was outdoors but inappropriately dressed for the rainy weather and she appeared to be intoxicated. RCMP attended and Jocelyn was arrested under the *Liquor Control and Licensing Act* for being intoxicated in a public place and lodged in a cell at the detachment at approximately 0730 hours, given the lack of alternatives to provide for her safety

Jocelyn was detained in cells without incident until she was assessed by the acting Watch Commander at approximately 1616 hours on June 23, 2016. He determined that she was fit to be released and she left walking at approximately 1619 hours.

At approximately 1745 hours on June 23, 2016, Port Alberni RCMP received a call that Jocelyn had shown up at a friend's residence, intoxicated. The friend reported that she was leaving her residence and did not know what to do about Jocelyn. Officers attended but could not initially find Jocelyn. When they returned to their police car, she was found to be trying to get into the back seat. The officers spoke to her and believed her to be intoxicated by drugs. They called for paramedics to assess her before they transported her to cells. BC Ambulance Service paramedics attended and found her to be intoxicated but fit for detention in cells. Given the lack of alternatives to provide for her safety, she was arrested under the *Criminal Code of Canada* for causing a disturbance. One of the officers had contacted Jocelyn's mother prior to her transport to the detachment to see if Jocelyn could stay with her as an alternative to detention, but she was unable to do so since she had Jocelyn's children. She suggested they take Jocelyn to hospital but was advised that Jocelyn did not fit the criteria.

Jocelyn was transported to the detachment and lodged in an open cell which is designed to house intoxicated prisoners. It did not have a raised cement bunk or mattress. She was not provided with a blanket. One of the police officers present at her arrest was going off shift and asked another member to make sure that Jocelyn had something to eat and drink during the night, because given her earlier detention and the short time of her release, the member was not confident that Jocelyn had anything to eat or drink in the last 24 hours. This message was passed on to a guard at approximately 0208 hours on June 24, 2016, at which time the guard reported that she was still under the influence of drugs. As a result, Jocelyn was not offered food or water. The message did not appear to be passed on to the guard who started their shift at 0700 hours on June 24, 2016. CCTV evidence showed Jocelyn apparently attempting to drink from the sink in the cell without success. Evidence presented at the inquest did not establish whether or not the water to the cell was turned on.

Over the detention from the 23rd to 24th of June, 2016, Jocelyn's behaviour deteriorated, most notably from approximately 0330 hours on the 24th onward. At that time, she was on the cell floor, moving sporadically. She displayed symptoms of withdrawal.

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At approximately 0720 hours on June 24, 2016, the acting Watch Commander came to the cells when he came on shift. He was advised that Jocelyn was still intoxicated but when he went into her cell he was concerned about her condition. She was lying on the cell floor mumbling. Her mouth was notably dry. She was non-verbal and twitching. He instructed the guard who had just come on shift to provide her with toast and water. This was done and left on the food tray in the cell door. Jocelyn did not arise from the floor or appear to attempt to consume the food or water. When the Acting Watch Commander returned to the cells approximately one hour later after attending a call, he got a cup of water and sat her up. Jocelyn drank the water with his assistance. He requested that BC Ambulance Service paramedics attend and assess her again.

Paramedics arrived at approximately 0844 hours. They found that she had an altered level of consciousness and a critically low blood glucose level. Her blood oxygenation was unreadable and her blood pressure was also very low. They gave her oral glucose as they could not get intravenous access and transported her to the West Coast General Hospital. She was examined by a physician there who determined that she was in grave condition. She was treated based on her clinical symptoms and an internal medicine specialist was summoned to assist. The specialist found her to be in multi-organ failure and circulatory collapse. He determined that she required a higher level of care and arrangements were made to have her airlifted to the Royal Jubilee Hospital in Victoria. Toxicology tests done at the West Coast General Hospital showed the presence of methamphetamine, benzoylecgonine (a metabolite and breakdown product of cocaine), and cannabis.

On arrival at the Royal Jubilee Hospital it was clear to physicians that Jocelyn was critically ill. Her cardiac enzymes were markedly elevated, and she appeared to have an anoxic brain injury from lack of oxygen to the brain. Family attended her bedside and were informed of the grim prognosis. While they were there Jocelyn went into cardiac arrest. CPR was commenced but after discussion with family those efforts were discontinued as being futile. Jocelyn died there at 1920 hours on June 24, 2016.

A forensic pathologist testified that he performed an autopsy on Jocelyn's body and found that she had died of acute myocarditis due to methamphetamine and cocaine toxicity. He testified that this is a known cause of myocarditis. It is a rare but not unknown complication that develops over a few days or hours. It is not dose-dependant, although the greater the consumption of drugs, the greater the risk. Both drugs are known to be cardio-toxic and their effects can be synergistic (operating together to produce an effect which exceeds or enhances the sum of their individual effects) . She was in a mild starvation state, but this did not contribute to her death. A forensic toxicologist also testified that stimulant drugs such as cocaine and methamphetamine have adverse effects on the heart and that the level of methamphetamine at the time of her death was at the high end for recreational use.

The jail guards who worked at the detachment in Port Alberni were employed by the City of Port Alberni and were supervised primarily by the Watch Commander at the detachment. The guards' duties included observing prisoners, preparing and serving them food, assisting with booking and release, and general upkeep of the cell block. Observations of prisoners were to be recorded in a logbook which detailed cell block and prisoner activities. Guards were required to maintain certifications in Basic First Aid and CPR.

When prisoners were lodged in cells either the arresting officer or a guard or both would complete a form called a C-13 which included such things as name, date of birth, prisoner details, their belongings, and reason for arrest. Review of the C-13 forms for the two arrests on June 13, 2016 showed inconsistencies in Jocelyn's name, date of birth (and therefore age), and whether there were concerns regarding violence. Various witnesses testified that, despite not wanting to be in detention, Jocelyn's conduct was primarily quiet and cooperative throughout.

Policy and training stated that prisoner checks were to be done at least once every 15 minutes. Closed circuit television (CCTV) cameras were located throughout the cell block, including the cells, with a display of monitors in the guard room and one monitor screen in the Watch Commander's office. Prisoner checks were to be done personally; they could be done by watching the CCTV, but policy and training explicitly stated that it was not to be a substitution for personal checks. How the observations were made was to be recorded in the logbook along with any notable behaviour. The guards were to initial their entries. The Watch Commander was to attend the cell block at the start and end of each shift to review prisoners and operations. They were also to sign the logbook when they attended the cell block. Guards were not to enter the cell of any prisoner without a police officer present.

Special policies and practices applied to prisoners who were found to be intoxicated. Responsiveness checks were to be conducted in a prescribed manner where it was observed to be an issue. Both C-13 forms from June 23rd had checks in a box marked "Responsiveness Checked". The earlier detention form noted "disorientation" and the later form detention noted "confusion". Provision of food and beverages could be withheld for up to eight hours to minimize the risk of aspiration/choking for prisoners who were found to be intoxicated. The cells were equipped with stainless-steel toilet/sink combination units. Water to each individual cell could be controlled with a shut-off valve. Prisoners who were to be released when sober were to be assessed by the Watch Commander or another police officer prior to release.

The evidence at inquest showed that Jocelyn was not monitored in accordance with policy and training either on the 23rd or the 24th of June. Personal checks were infrequently done but were marked as completed in the logbook. Most personal checks that were done were very brief. Observations as to her behaviour were primarily limited to noting that she was still intoxicated. There was no mention of the officer's request for provision of food and water noted in the logbook.

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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: Deputy Commissioner, E-Division, Royal Canadian Mounted Police

1. Provide training for all members regarding the definition of the age of majority in BC and relevant legislative requirements regarding minors.

   Presiding Coroner Comment:

   The jury heard evidence that the definition of a minor in BC according to the Age of Majority Act is a person under the age of 19 years. Other Provincial legislation contains requirements that minors be treated differently than adults. Federal legislation such as the Canadian Criminal Code defines a minor as being under the age of 18 years. The evidence showed that the police officers who dealt with Jocelyn were not clear on whether or not she was a minor and were unaware of the implications of that determination.

2. Create policies to ensure prisoners' access to water in cells is recorded and can be confirmed by supervisory staff.

   Presiding Coroner Comment:

   The jury heard evidence that water to individual cells can be shut off. They saw on CCTV that she appeared to try to drink water from the sink but appeared to be unsuccessful. No witness could say with certainty that the water to her cell was turned on. Evidence was led that if water was shut off to a cell it should have been noted in the logbook but the logbook was shown to have recording deficiencies. The RCMP have ultimate responsibility to care for prisoners in their custody and the restriction of water should be made obvious and easily verifiable by supervisory staff.

3. Create policies to ensure that when food is offered, accepted, refused, or consumed by prisoners it is recorded in the guard logbook. Reasons for withholding food or water should also be detailed in logbook.

   Presiding Coroner Comment:

   Testimony showed that details concerning prisoners' consumption of food and water was not recorded in the logbook.

4. Ensure members' and guards' training includes mental health and addictions awareness, local cultural awareness, and how to access employee trauma counselling.

   Presiding Coroner Comment:

   The jury heard evidence that training in these areas was lacking. Both guards and members were adversely affected by this incident and a guard who testified to this did not receive trauma counselling.

5. Ensure that job descriptions and responsibilities for members and guards regarding prisoners are listed and available for all staff to access.

   Presiding Coroner Comment:

   The jury heard evidence that members and guards were not clearly aware of responsibilities and duties regarding prisoners. Joint participation in filling out the C-13 forms may have contributed to the inconsistencies noted.

6. Install audio monitoring in cell block corridors of all RCMP detachments in BC within 5 calendar years.

   Presiding Coroner Comment:

   The jury heard and saw evidence that it is not possible to hear most activity from cells and cell corridors, including possible calls for assistance.

7. Develop policy requiring a release plan to ensure safety of minors upon release from custody.

   Presiding Coroner Comment:

   The jury heard evidence that it was normal to release minors without a plan. The evidence showed that Jocelyn was released in wet clothes, with no shoes and no communication with family, agencies, or others.

8. Require members to transport persons in detention to a local health facility for assessment when their health status is unclear.

   Presiding Coroner Comment:

   The jury heard that police officers and guards are not trained to assess health status.

9. Share a copy of this verdict with detachments throughout 'E' Division.

   Presiding Coroner Comment:

   The jury heard that the Unit Supplements for the Port Alberni detachment were reviewed and updated following this incident but that other detachments would not necessarily be aware of the enhancements to policy or lessons learned.

To: Deputy Commissioner, E-Division, Royal Canadian Mounted Police
City of Port Alberni
Minister of Public Safety and Solicitor General
Nu-chah-nulth Tribal Council
First Nations Health Authority
Vancouver Island Health Authority

10. Provide an on-call health care professional to assess detainees in cells.

    Presiding Coroner Comment:

    Multiple witnesses testified that drug and alcohol use disorders are medical issues. Many of the people the RCMP deal with have those medical issues. The jury heard that RCMP members are not trained or equipped to deal with medical issues.

11. Develop a program to provide appropriate cultural support for detainees.

    Presiding Coroner Comment:

    Witnesses stated that cultural support is not available based on present policies and procedures.

To: Vancouver Island Health Authority

12. Ensure that a Crisis Response Team is available in Port Alberni on nights and weekends.

    Presiding Coroner Comment: The jury heard that the Crisis Response Team was available during business hours and that service was sporadic due to workload.

13. Ensure an internal medicine specialist is available onsite at West Coast General Hospital in Port Alberni.

Presiding Coroner Comment:

The jury heard that space for the internal medicine specialist services was being removed from the West Coast General Hospital and that onsite availability was essential for patients requiring a timely response.

To: Ministry of Public Safety and Solicitor General
Ministry of Mental Health and Addictions

14. Provide permanent funding to the Port Alberni Indigenous Safety Team for a full-time social worker and youth advocate.

Presiding Coroner Comment:

Multiple witnesses stated that the current Team was temporary. Since the Team has been in place there has been a decline in persons needing to go to the cells due to earlier intervention.

To: City of Port Alberni, OIC Port Alberni RCMP Detachment

15. Implement annual performance reviews, certifications, and training for city employees working as guards at the Port Alberni RCMP detachment.

Presiding Coroner Comment:

Multiple witnesses stated that guards had minimal certifications in First Aid. Witnesses also stated that training was minimal, and the City did not conduct annual performance reviews.

16. Implement measures to diversify work force.

Presiding Coroner Comment:

Multiple witnesses noted a lack of diversity in staff. The jury heard that it would be a benefit to collaborate and work with the Nuu-chah-nulth Education and Training Program.

To: Ministry of Mental Health and Addictions

17. Give special priority to youth facing addiction and mental health issues and to establishing First Nations operated treatment centres.

Presiding Coroner Comment:

The jury heard that these are not current Ministry priorities. They heard from multiple witnesses that there is a gap in supports for youth facing addiction and mental health issues. They also heard that a significant proportion of Indigenous youth were trapped in the current systems. There is little to no support for Indigenous 'land-based' healing or treatment centres for youth.

To: Nu-chah-nulth Tribal Counsel

18. Provide RCMP with cultural diversity supports and support for release planning for Indigenous detainees.

Presiding Coroner Comment:

Multiple witnesses stated that there was no apparent action taken to advise family, agencies, or others that a young Indigenous person was being detained and released without supports.

To: Quu'asa

19. Offer trauma informed practice and seek funding for permanent harm reduction staff including a harm reduction youth worker.

Presiding Coroner Comment:

The jury heard from multiple witnesses that funding for a harm reduction worker was temporary. They also heard that there was a great need for harm reduction staff for young people in this community.

To: Nu-chah-nulth Tribal Council
City of Port Alberni
Vancouver Island Health Authority
Tseshaht First Nation
Hupacasath First Nation
First Nations Health Authority

20. Collaborate to make an application to "Foundry" to provide services in Port Alberni for local, then regional populations.

Presiding Coroner Comment:

The jury heard that there are funding opportunities available for mental health and addictions through a Provincially funded private agency providing a wide variety of services for young people but that it is not currently available in Port Alberni.

To: Nu-chah-nulth Tribal Council
City of Port Alberni

21. Advocate for a Justice Centre in the Nuu-chah-nulth territory to address the over representation of first nations people in custody.

Presiding Coroner Comment:

Multiple witness testified that there is a high proportion of Indigenous people brought into custody. They also heard that a Justice Centre is not available on Vancouver Island (Nuu-chah-nulth territory).

22. Appoint a First Nations civilian monitor in all cases where the affected person is Indigenous.

Presiding Coroner Comment:

The jury heard that there is no Indigenous oversight in cases involving Indigenous affected persons.

To: City of Port Alberni
Nu-chah-nulth Tribal Council
Deputy Commissioner, E-Division, Royal Canadian Mounted Police

23. Seek membership on the board of directors of the Port Alberni Shelter Society Board.

Presiding Coroner Comment:

The jury heard that there is a lack of representation from community agencies with an interest in community wellness and social issues.

To: Vancouver Island Health Authority
First Nations Health Authority
Ministry of Children and Family Development
USMA
Nu-chah-nulth Tribal Council
Maa-Nulth Nations
Alberni-Clayoquot Regional District

24. Collaborate and create a holistic wellness centre within the Regional District that includes: a safe space for youth, a sobering centre, mental health and addiction beds, certified health care professionals, an on- call physician, certified security guards, and appropriate cultural and spiritual supports.

Presiding Coroner Comment:

The jury heard from multiple witnesses that there is a gap in services for youth accessing mental health and addictions issues who are often detained in RCMP cells because there is no alternative safe place.