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

File Number:2019-3001-0015

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

CHAN	NICOLE CHUN WAI
SURNAME	GIVEN NAMES

An Inquest was held at The Burnaby Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates: January 23 to February 1, 2023

before: Susan Barth, Presiding Coroner.

into the death of Chan (Last Name) Nicole (First Name) Chun Wai (Middle Name) 30 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: January 27th, 2019 (Date) Between 0000 and 0745 hours (time)

Place of Death: 910 – 1708 Columbia Street (Location) Vancouver, BC (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) Occlusion of the blood vessels to the neck

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Ligature strangulation

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 1st day of February AD, 2023

Susan Barth
Presiding Coroner's Printed Name

S. J. Barth
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Barth
Inquest Counsel:	John McNamee and Steven Liu
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Gloria Ng and Trudy Au, counsel for Family David McKnight and Naomi Krueger, counsel for Chief Constable Palmer of the Vancouver Police Department Adam Howden-Duke, counsel for the Vancouver Coastal Health Authority David Pilley, counsel for Dr. Kiran Sayyaparaju Selina Gyawali and Gray Morfopoulos, counsel for Dr. Noah Susswein

The Sheriff took charge of the jury and recorded 12 exhibits. 34 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.

Nicole Chun Wai Chan was known to her friends and family as a loving and ambitious individual who always wanted a career as an officer with the Vancouver Police Department (VPD). A family member testified that she wanted to speak up for victims as a police officer and find justice for individuals whose voice may not be heard. She was proud to be a VPD officer.

During her late teen years, Nicole Chan befriended a VPD officer who answered her questions about a career in policing and provided guidance to her. He helped her obtain a volunteer position in policing as well as jobs in security and loss prevention.

On May 27, 2008, Nicole Chan was hired as an auxiliary jail guard with VPD and was offered a full-time guard position on January 11, 2009. After completing the application process for a policing position with VPD, Ms. Chan was recommended for hire and became a VPD officer in September of 2011. She attended police academy at the Justice Institute of British Columbia beginning September 21, 2011.

On May 25, 2012, she was assigned to District 1 Team 9 with VPD.

As part of her VPD application, Ms. Chan disclosed that in 2006, when she was 17 years of age, she took a large amount of Tylenol. This did not impede her hiring as a police officer. A psychologist who did work for the VPD (VPD psychologist), testified that when Ms. Chan was hired, VPD officers administered psychological testing that he later interpreted. He identified 14 concerns for follow up on Ms. Chan's testing and noted that this was a higher than average number.

On October 25, 2012, Ms. Chan was involved in a motor vehicle incident where her vehicle crashed into a pole. This occurred after her boyfriend ended their relationship. It was believed this was an intentional act, so she was apprehended under the *Mental Health Act* (*MHA*). This incident was treated as a potential suicidal event but Ms. Chan stated that it was an accident, and that she didn't see the pole, however she told a friend later that she was trying to harm herself. Ms. Chan was off work for a short time and was cleared by Dr. Nemetz to return to duty on November 1, 2012.

In May 2016, Ms. Chan was referred to the VPD psychologist for anxiety. At that meeting, Ms. Chan disclosed that she tried to kill herself with Tylenol before entering the academy, and then again after becoming an officer by using a vehicle in a motor vehicle incident. She denied being suicidal on the day of the meeting and discussed stressors in her life. He advised she should see her family physician to rule out any physical reason for her anxiety and to talk about possible medications. He asked her to follow up with him in two weeks.

On June 11, 2016, Ms. Chan was reported missing and was later located in a motel in Burlington, Washington. Two VPD members spoke with Ms. Chan by phone, and she agreed to come back to Canada with them. The officers drove to Burlington and brought Ms. Chan back without incident.

On arrival in Vancouver, Ms. Chan was taken to meet with the VPD psychologist who spoke with her and referred her to another psychologist for ongoing treatment. She was placed on sick leave, began medication, and continued to meet with her psychologists regularly.

On August 22, 2016, Ms. Chan began a return to work assignment with the Telephone Response Team (TRT) as supported by her psychologists. On February 10, 2017, her psychologist developed a graduated return to work plan that would assist her to eventually return to regular work as a VPD officer.

On September 18, 2017, Dr. Mackoff was contacted due to reports that Ms. Chan was having more difficulties with her mental health and suicidal thoughts. He met with her and advised that she should be off work and would require an independent medical evaluation (IME) to determine her psychological fitness before returning to duty. On February 25, 2018, Ms. Chan returned to the TRT as part of her return to work plan.

Ms. Chan had been regularly seeing a private psychologist, since January of 2017, for treatment of persistent depressive disorder. The private psychologist was not part of VPD, but Ms. Chan gave permission for him to talk with her VPD treatment providers.

On January 18, 2018, Ms. Chan told the private psychologist that she had filed a work complaint with the VPD police chief regarding abuses of power within VPD that included sexual relationships with senior officers who had influence over her career path and threats of extortion for sexual favours from one officer. These sexual relationships occurred between March 2016 and October 2017.

Over the next several months, Ms. Chan appeared preoccupied with waiting for results from the Human Resource (HR) investigation into her allegations. Ms. Chan and Dr. Susswein worked on stress reduction, anxiety management, relationship conflict management and mindfulness. Ms. Chan began referring to her policing career in the past tense and they discussed future planning.

The private psychologist's last appointment with Ms. Chan was on December 21, 2018. She appeared upbeat and future oriented but was 'outraged' that one of the officers she lodged the complaint appeared able to keep his job despite proceedings under the *Police Act*.

On October 30, 2018, Ms. Chan met with a registered psychologist hired by WorkSafeBC (WSBC psychologist) to review the impacts of two events for Ms. Chan. The first event was a work incident when a less lethal weapon failed to discharge and the second was Ms. Chan's sexual relations with superior officers.

The WSBC psychologist met with Ms. Chan and was also able to review medical records provided by Ms. Chan's other mental health service providers. This resulted in a diagnosis of major depressive disorder recurrent in partial remission. The WSBC psychologist suggested certain restrictions, limitations, and steps for moving forward that included seeing a clinical counsellor. Ms. Chan saw a clinical counsellor and had six appointments between December 10, 2018, and January 21, 2019.

In the evening of January 26, 2019, Nicole Chan's partner called 911 because he was concerned for her safety. They had a fight that resulted in Ms. Chan threatening self-harm and suicide. VPD officers were dispatched and VPD human resources (HR) staff were also notified.

VPD officers apprehended Ms. Chan under Section 28 of the *MHA* and took her to the Assessment and Access Centre (AAC) for assessment by a psychiatrist. After assessing Ms. Chan, the psychiatrist released her after determining that there were no grounds to hold her under Section 28 of the *MHA*.

The VPD officers in attendance unsuccessfully attempted to contact the private psychologist and were able to reach the VPD psychologist for support and direction. The VPD psychologist conveyed the importance of communicating to the assessing psychiatrist that Ms. Chan had a long history of suicidal ideation and attempts and that it was imperative for the psychiatrist to know this.

The police officers asked to speak to the psychiatrist, but their request was declined. They shared with the nurse that Ms. Chan had a history of suicide attempts and that she was held under the MHA in 2012. The nurse shared this information with the psychiatrist then returned to let the officers know that the decision to release Ms. Chan hadn't changed based on the information shared.

The VPD psychologist then provided direction to get a commitment from Ms. Chan not to hurt herself or others and to ask if there was someone she felt safe with who could stay with her. The VPD officers who drove Ms. Chan home offered to call friends or family to be with her, but she declined. They offered to walk her up to her apartment, which she also declined. She appeared to be in a better frame of mind, promised to call a friend, and told them "I promise I won't hurt myself or anyone else."

She agreed to text the officers once she was in her apartment, which she did. At 2356 hours on January 26, 2019, she sent a text message saying, "I'm good, safe and sound". The officers then departed.

When Ms. Chan arrived at the apartment, her partner was in the process of leaving to spend the night with friends who were there to pick him up. Her partner and friends were surprised to see her home and were very concerned for her wellbeing. They called 911 and were told there was nothing further that could be done.

Ms. Chan spoke by phone that night with the friend who had helped her with her efforts to join the VPD, sharing the events that had unfolded. She was very upset that VPD HR had been involved and had attended the hospital. She felt that their presence at the hospital would result in her never being a regular VPD member again. She was extremely upset and the friend offered for her to come and stay with him and his family for the night, but she indicated that she just needed to sleep and would connect with him in the morning.

The following morning, Ms. Chan's partner came back to their apartment to check on her and found her deceased. He called 911 and BC Ambulance Service paramedics attended the residence but did not attempt to revive her as death was apparent.

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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: Vancouver General Hospital, Access and Assessment Centre (AAC)

1. Recommend that policy ensures that the attending doctor has direct communications with paramedics, police officers, and/or friends and family members in attendance.

   Presiding Coroner Comment: *VPD officers asked to speak to the AAC psychiatrist and were denied. At one point, an officer had Dr. Mackoff on the phone and could have passed the phone to the psychiatrist, but the communication did not occur.*

2. Review physician's ability to access to historical patient information from all sources.

   Presiding Coroner Comment: *The AAC psychiatrist gave evidence that having more information regarding Ms. Chan's mental health history would have been beneficial for assessment.*

3. Develop a process to ensure the attending doctor can take phone calls from community healthcare providers.

   Presiding Coroner Comment: *Two of Ms. Chan's psychologists indicated that it was difficult for them to reach attending physicians via phone.*

To: Chief Constable, Vancouver Police Department

4. Mandatory psychological clinical interviews should be a part of every potential police officers' recruitment process whereby the psychologist's recommendations are considered.

   Presiding Coroner Comment: *Dr. Mackoff gave evidence that Ms. Chan's hiring assessment expressed 14 concerns where the average is 5. Dr. Mackoff suggested that psychological interviews be mandatory for all candidates.*

5. Ensure respectful workplace training is mandatory, rigorous, in-person, and on a regular basis for all ranks of police officers.

   Presiding Coroner Comment: A *VPD officer said there is very little interactive training with respect to workplace harassment and that supervisors are not given specific training.*

6. Training specific to promotions should include formal administrative and management training.

   Presiding Coroner Comment: *VPD HR officers indicated they did not have any education in Human Resources management while being assigned to that section and indicated that supervisors only get a 7-day training course to supervise police constables.*

7. Have a human resource or peer support case representative in regular contact with all employees with mental health issues, and the family and/or support circle if permitted by the employee, to establish and build a relationship and provide continuity of care.

   Presiding Coroner Comment: *Witnesses said that peer support was available in 2019. As Ms. Chan was off work since 2017, it was not clear if she knew of the Peer Support program.*

8. Annual psychological check-ins with a psychologist should be mandatory for all police officers.

   Presiding Coroner Comment: *Witnesses said that major crime units and forensic units get regular check-ins. Such check-in should be made available to all officers - all ranks and all sections.*

9. The respectful workplace policy should recognize rumours and gossip as an example of unprofessional behaviour.

   Presiding Coroner Comment: *An officer testified that rumours and gossip about Ms. Chan's situation and about the two of them had impacted her.*

10. Police officers in the human resources department should receive specific training relative to the duties of a human resources professional.

    Presiding Coroner Comment: *VPD HR officers testified they did not have any education in Human Resources management while being assigned to that section.*

11. Ensure each section within the human resources department works interdependently rather than independently of each other.

    Presiding Coroner Comment: *VPD HR witnesses provided information about Ms. Chan's involvement with their section but were unable to answer certain questions because they were unaware what was occurring with Ms. Chan's file in other sections of the HR department.*

To: Minister of Health

12. Consider integrating a specific database containing medical records of patients who have suicidal ideations across all health authorities.

    Presiding Coroner Comment: *Mental health providers gave evidence that they do not have access to other Provincial Health Authority databases which would be beneficial to fully understand a patient's history.*