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

File Number: 2017-0597-0103

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

Cote	**Heather Louise**
SURNAME	GIVEN NAMES

An Inquest was held at the Kelowna Law Courts, in the municipality of Kelowna

in the Province of British Columbia, on the following dates: September 18 - 21, 2023

before: Susan Barth, Presiding Coroner.

into the death of Cote (Last Name) Heather (First Name) Louise (Middle Name) 60 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: August 26, 2017 (Date) 2037 hours (Time)

Place of Death: #9 - 1502 Nicola Avenue (Location) Merritt, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Mixed illicit and prescription drug toxicity

Due to or as a consequence of

Antecedent Cause if any: b)

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 21st day of September AD, 2023

Susan Y. Barth
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Barth
Inquest Counsel:	Christopher Godwin
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	

The Sheriff took charge of the jury and recorded 8 exhibits. 16 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.

Heather Louise Cote lived in a motel room in Merritt with a family member and her two small dogs. She was diagnosed with several significant medical issues and had a long history of substance use that was being treated with methadone.

On August 26, 2017, Merritt RCMP obtained a search warrant for Ms. Cote's residence and executed the warrant at approximately 1800 hrs. Ms. Cote was arrested and given the option to be held in RCMP cells at the detachment or stay in the back of a police car while the search was being executed. Ms. Cote chose to stay in the police car. A female officer was brought to the scene to perform a body search before Ms. Cote was placed in the police car. The officer conducting the body search only located cash in a pocket.

The police officer guarding Ms. Cote had the air conditioning on in the police car to ensure Ms. Cote's comfort. Ms. Cote was also given a bottle of water and RCMP allowed her to have one of her small dogs in the car. The officers were familiar with Ms. Cote and aware that her dog was very anxious when separated from her.

Once the search of the motel room was completed, RCMP planned to have Ms. Cote sign a document regarding appearing in court on charges before releasing her from their custody.

Before that occurred, Ms. Cote indicated that she was feeling unwell and needed to use the bathroom. The officers allowed her back into the motel room where she entered the bathroom.

Moments later, an officer heard her call out for help then witnessed her collapsing. 911 was called to summon BC Emergency Health Services (BCEHS) paramedics. The officer assessed Ms. Cote and it was established that she was breathing and had a pulse but was unresponsive. Ms. Cote was then placed in the recovery position and was monitored continuously.

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Merritt Fire Department (MFD) first responders arrived within 5 minutes, assessed Ms. Cote and determined that she was pulseless and not breathing. MFD first responders made resuscitation efforts including cardiopulmonary resuscitation (CPR), the use of a bag-valve mask (BVM) and an automatic external defibrillator (AED) until paramedics could attend the scene. At the time both ambulances assigned to Merritt were at other calls, resulting in delayed paramedic response to the scene.

BCEHS received the page at 1953 hours while finishing another call at the Britton Creek rest area and arrived at the scene at 2027 hours. The paramedics switched to their own AED and it reported that no shocks were advised. It was established that Ms. Cote was in cardiac arrest, with no electrical activity in the heart, no breathing and no reaction to a pain stimulus. They called the emergency physician on standby, and said that the fire department had provide 40 minutes of CPR and received 17 messages of 'no shocks' their AED. The emergency physician confirmed that the paramedics should cease resuscitation efforts, and death was pronounced at 2033 hours.

An autopsy was completed by a forensic pathologist who testified that the cause of death was from a mixed illicit and prescription drug toxicity.

The forensic toxicologist testified that cocaine/benzoylecgonine, methadone, and carfentanil were detected in potentially lethal amounts. Methamphetamine was also detected. The forensic toxicologist cautioned that interpretation of methadone must consider tolerance and said that it was likely that the carfentanil in her system was consumed within 60 minutes prior to her death. Ms. Cote's physician testified that she was prescribed a high dosage of methadone as a harm reduction tool and that her tolerance to methadone was high.

A Director with BCEHS Patient Care Delivery reviewed this case and testified that both ambulances in Merritt were fully staffed that day but were both dispatched to scenes in the surrounding area which delayed paramedic response time to this incident. The Director also stated that the Province of BC has recently increased resources significantly for rural stations in BC, including Merritt.

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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: Minister of Public Safety and Solicitor General
E Division, Royal Canadian Mounted Police (RCMP)

1. When preparing to execute a search warrant, consideration should be given to ensuring an officer of the same gender as the subject(s) be available from execution of the warrant to release of the subject. Subjects should be supervised at all times while in custody during execution of a search warrant.

   Presiding Coroner Comment: *A female officer was only available for 10 minutes to perform a body search leaving Ms. Cote unsupervised while she used the bathroom. It is suspected that this is when the drugs causing her death were consumed.* ***E Division of the RCMP is to take the lead on this recommendation.***