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

File Number: 2017-0743-0052

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

Solonas	Nadine Marcy
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates: May 23rd, 2023 to May 30th, 2023

before: Susan Barth, Presiding Coroner.

into the death of Solonas (Last Name) Nadine (First Name) Marcy (Middle Name) 40 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: October 2nd, 2017 (Date) 0824Hrs (time)

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

Medical Cause of Death:

(1) Immediate Cause of Death: a) Blunt Force Head Injury

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 30 day of May AD, 2023

Susan Barth
Presiding Coroner's Printed Name

Presiding Coroner's Signature

Province of British Columbia

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

Solonas	**Nadine Marcy**
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Barth
Inquest Counsel:	Steven Liu
Court Reporting/Recording Agency:	Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 12 exhibits. 27 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.

Nadine Marcy Solonas was known to her family as a happy child who was loved by her parents, grandparents, aunts, and uncles. A social worker who provided support to Ms. Solonas and her children shared how much Ms. Solonas loved the visits with her children.

A nurse at Central Interior Native Heath (CINH) who worked closely with Ms. Solonas during a pregnancy gave evidence at this inquest. The nurse described Ms. Solonas as being an extremely intelligent woman who was a victim of inter-generational trauma, something Ms. Solonas tried very hard to overcome. Ms. Solonas' mother and father both attended residential day schools in British Columbia.

On October 1, 2017, at approximately 0420 hours, police received a 911 call from Ms. Solonas' partner, requesting assistance from police and paramedics because of an assault. On arrival at the motel where Ms. Solonas and her partner were living, police discovered that residents in the motel had gone to the suite where Ms. Solonas was living, and a disagreement resulted in in Ms. Solonas receiving injuries to her head. Ms. Solonas' partner said that the assailants had also assaulted them two days previously.

Police at the scene discovered that there was a no contact order preventing Ms. Solonas from interacting with her partner. Police placed Ms. Solonas under arrest for breaching the no contact order and took her to the local RCMP detachment. Police noted bruising to Ms. Solonas' face but believed it to be old and not from the recent assault.

At the request of the police, when paramedics finished at the scene, they went to the detachment to assess Ms. Solonas, who refused treatment. A guard at the detachment and Ms. Solonas recognized one another from when Ms. Solonas was a child.

The guard could see that Ms. Solonas was untrusting of the police and paramedics and started a conversation. The guard convinced Ms. Solonas to allow the paramedics to do a medical assessment. Once assessed, Ms. Solonas agreed to go to the hospital for a more in depth assessment and treatment. At 0548 hours, Ms. Solonas was admitted to GR Baker Memorial Hospital (GRBMH).

Ms. Solonas told the triage nurse that she had been assaulted and that some of the bruising to her face was not from the assault that morning.

Ms. Solonas's vital signs were stable and at 0620 hours Ms. Solonas was assigned a room. She was given a bed with a blanket to wait for assessment by a physician.

When Ms. Solonas was next checked at 0705 hours by a nurse, she was unresponsive. A physician was called and ordered an urgent computed tomography (CT) scan, which revealed a subdural hematoma (brain bleed). This was complicated by a serious blood clotting deficiency that was noted in a blood test taken earlier. The treating physician testified that a subdural hematoma rarely occurs spontaneously and is usually caused by accidents or assaults.

A Vancouver neurosurgeon reviewed the CT scan, recommended immediate transport to a larger trauma centre, and directed treatment until Ms. Solonas could receive a higher level of care. Flight paramedics arrived at GRBMH at 1145 hours to provide continuing care and transported her to Vancouver General Hospital (VGH). Care was handed over to VGH physicians at 1425 hours.

Another CT scan revealed that the subdural hematoma had grown larger and was impacting Ms. Solonas' brain stem. The neurosurgeon believed that the CT scan may have shown both acute and older blood but it was difficult to tell conclusively. The neurosurgeon also noted that, while this injury could have resulted from an assault, Ms. Solonas did not have a skull fracture and her reduced clotting ability made it possible for this to have occurred spontaneously.

After further assessment the neurosurgeon determined that there were no treatment options available for Ms. Solonas, and comfort care was provided until her death at 0824 hours on October 2, 2017.

Dr. Matthew Orde testified that he conducted an autopsy and the cause of death was blunt force head injury. Dr. Orde concluded that the injury leading to Ms. Solonas' death occurred "likely within a couple of days or so prior to death."

The Independent Investigation Office (IIO) completed an investigation into this incident and determined that there was no action or inaction by the officers involved that contributed to Ms. Solonas' death.

Province of British Columbia

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

Solonas	**Nadine Marcy**
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: Deputy Commissioner, RCMP 'E' Division

1. Create an Indigenous support position that is on call 24/7 for when an Indigenous person has been taken into custody. This supportive role would assist the person in custody if they were refusing medical treatment or generally feeling untrusting of first responders and not cooperating. This will ensure the individual has a non-uniformed, civilian employee to build a connection with and support a more culturally safe environment when required.

   Presiding Coroner Comment: *On October 1st, 2017, when Ms. Solonas was taken into custody, she was refusing medical treatment, but a guard who was familiar to her was able to calm Ms. Solonas down and get her to accept the help she needed. Paramedics testified that the guard was able to calm Ms. Solonas down and have her agree to medical treatment.*