Ministry of Public Safety and Solicitor General
BC Coroners Service

Case No.: 2018-0292-0033

CORONER'S REPORT

INTO THE DEATH OF

s.22	s.22
SURNAME	GIVEN NAMES

OF

s.22
MUNICIPALITY OF RESIDENCE

I, Kimberly D Isbister, a Coroner in the Province of British Columbia, have investigated the death of the above named, which was reported to Coroner Nis Schmidt on the s.22 and as a result of such investigation have determined the following facts and circumstances:

Gender:	☒ MALE ☐ FEMALE		
Age:	s.22 YEARS		
Death Premise:	HOSPITAL/PSYCHIATRIC		
Place/Municipality of Death:	s.22	Date of Death:	s.22
Municipality of Illness/Injury:	COQUITLAM	Time of Death:	0430 HOURS

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death:	a) Atherosclerotic Cardiovascular Disease
	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:	History Of Tobacco Use, Alcohol Misuse, Class III Obesity
BY WHAT MEANS	Natural Disease Process

CLASSIFICATION OF DEATH ☐ ACCIDENTAL ☐ HOMICIDE ☒ NATURAL ☐ SUICIDE ☐ UNDETERMINED

Date Signed: MARCH 31, 2020

Kimberly D Isbister, Coroner
Province of British Columbia

This document has been prepared pursuant to the authority of the Chief Coroner, Coroners Act, S.B.C 2007 c.15 Section 53(2)

BRITISH COLUMBIA

CORONER'S REPORT

INTO THE DEATH OF

SURNAME	GIVEN NAMES
s.22	s.22

INVESTIGATIVE FINDINGS

On s.22 the death of Mr. s.22 was reported to the BC Coroners Service by the Coquitlam RCMP. Mr. s.22 had been a resident at Colony Farm Psychiatric Hospital since s.22

Investigation revealed that Mr. s.22 was last seen to be alive by staff at approximately 0210 hours on s.22 and noted as breathing and sleeping alone within his room. During the following check at 0325 hours, staff noted that Mr. s.22 hands were cyanotic and he was unresponsive. Emergency services were contacted, and bystander CPR was applied. Upon arrival of paramedics, resuscitative efforts were continued; however, Mr. s.22 was unresponsive to these efforts and pronounced deceased at 0430 hours.

Mr. s.22 medical history consisted of alcohol misuse, which resulted in s.22 s.22 , tobacco use, and he suffered from obesity.

POST MORTEM/TOXICOLOGY EXAMINATION

A post mortem examination was conducted at Royal Columbian Hospital on s.22 which revealed mild to moderate atherosclerosis of two major coronary arteries. Examination of the brain revealed moderate to severe neurodegenerative changes of the anterior and mediodorsal nuclei of the thalamus and orbitofrontal cortex. There were no traumatic injuries, ongoing infectious process, or life-threatening natural disease identified.

Toxicology analysis on post mortem samples revealed no alcohol or illicit drugs. Trazadone was identified at a sub-therapeutic level and valproic acid was determined to be within a therapeutic level.

CONCLUSION

I find that Mr. s.22 died in s.22 on s.22 of atherosclerotic cardiovascular disease. I classify this death as natural and make no recommendations.

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Kimberly D Isbister, Coroner
Province of British Columbia

Ministry of Public Safety and Solicitor General
BC Coroners Service

Case No.: 2017-0364-0094

CORONER'S REPORT

INTO THE DEATH OF

s.22	s.22
SURNAME	GIVEN NAMES

OF

s.22
MUNICIPALITY OF RESIDENCE

I, Nicki Dennison, a Coroner in the Province of British Columbia, have investigated the death of the above named, which was reported to me on the s.22 and as a result of such investigation have determined the following facts and circumstances:

Gender:	☒ MALE ☐ FEMALE		
Age:	s.22 YEARS		
Death Premise:	PSYCHIATRIC HOSPITAL		
Place/Municipality of Death:	s.22	Date of Death:	s.22
Municipality of Illness/Injury:	COQUITLAM	Time of Death:	0530 HOURS

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Coronary Artery Disease

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: Previous Myocardial Infarcts, Hyperlipidemia, Schizophrenia

BY WHAT MEANS Natural Disease Process

CLASSIFICATION OF DEATH ☐ ACCIDENTAL ☐ HOMICIDE ☒ NATURAL ☐ SUICIDE ☐ UNDETERMINED

Date Signed: JULY 6, 2017

N Dennison

Nicki Dennison
Province of British Columbia

This document has been prepared pursuant to the authority of the Chief Coroner, Coroners Act, S.B.C 2007 c.15 Section 53(2)

BRITISH COLUMBIA

CORONER'S REPORT

INTO THE DEATH OF

s.22	s.22
SURNAME	GIVEN NAMES

INVESTIGATIVE FINDINGS

On s.22 the death of Mr. s.22 was reported to the B.C. Coroners Service by the Forensic Psychiatric Hospital in Coquitlam. Mr. s.22 had been found unresponsive in bed in his room by staff. Paramedics attended to the scene and confirmed death.

Investigation revealed that Mr. s.22 was last seen by staff at approximately 0500 hours when he left his room to use the bathroom. He did not express any acute complaints or concerns to staff at that time and returned to bed. At approximately 0630 hours, during routine hourly checks, hospital staff found him unresponsive. Mr. s.22 had been admitted to hospital under Section 30 of the *Mental Health Act* and had been at the Forensic Psychiatric Hospital since s.22 . He was in the maximum security ward. He had a longstanding cardiac history that was well documented in the hospital medical charting. He was followed by the staff psychiatrist and a staff physician for both his psychiatric and medical care needs. Mr. s.22 had a history of coronary artery disease, prior acute myocardial infarcts, hyperlipidemia, schizophrenia and s.22 He was noncompliant with his cardiac care needs and refused to take prescription medications to manage his disease.

At the scene, Mr. s.22 was found lying supine in bed in his single locked room. Body exam revealed no evidence of significant injury or trauma. Post mortem changes were consistent with his found position and the time frame provided by staff. Police attended to the scene and had no concerns of foul play.

POST MORTEM/TOXICOLOGY EXAMINATION

An autopsy and toxicological examination were not conducted as Mr. s.22 medical history was well documented and the scene, circumstances and body examination were all consistent with a natural death.

CONCLUSION

I find that s.22 died in s.22 on s.22 of coronary artery disease. Previous myocardial infract(s), hyperlipidemia and schizophrenia are considered contributory factors in the death. I classify this death as natural and make no recommendations.

N. Dennison

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Nicki Dennison
Province of British Columbia

Ministry of Public Safety and Solicitor General
BC Coroners Service

Case No.: 2016-0225-0133

CORONER'S REPORT

INTO THE DEATH OF

s.22	s.22
SURNAME	GIVEN NAMES

OF

s.22
MUNICIPALITY OF RESIDENCE

I, Tara Louise Devine, a Coroner in the Province of British Columbia, have investigated the death of the above named, which was reported to me on the s.22 and as a result of such investigation have determined the following facts and circumstances:

Gender: ☒ MALE ☐ FEMALE

Age: s.22 YEARS

Death Premise: HOSPITAL

Place/Municipality of Death: s.22

Date of Death: s.22

Municipality of Illness/Injury: COQUITLAM

Time of Death: 0653 HOURS

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Undetermined Natural Causes

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:

BY WHAT MEANS Natural disease process.

CLASSIFICATION OF DEATH ☐ ACCIDENTAL ☐ HOMICIDE ☒ NATURAL ☐ SUICIDE ☐ UNDETERMINED

Date Signed: MARCH 5 , 2018

Tara Louise Devine, Coroner
Province of British Columbia

This document has been prepared pursuant to the authority of the Chief Coroner, Coroners Act, S.B.C 2007 c.15 Section 53(2)

BRITISH COLUMBIA

CORONER'S REPORT

INTO THE DEATH OF

SURNAME	GIVEN NAMES
s.22	s.22

INVESTIGATIVE FINDINGS

On s.22 at approximately 0653 hours, the death of Mr. s.22 was pronounced at s.22 s.22 The BC Coroners Service initiated an investigation.

Investigation revealed that Mr. s.22 had resided at Colony Farms, a residential mental health facility since s.22 He had a reported medical history that included obesity, schizophrenia, and high cholesterol. In his ward, Mr. s.22 received twenty-four hour nursing care. It was reported that the facility had a Norovirus outbreak on s.22 From s.22 Mr. s.22 had mild symptoms including fatigue, nausea, and episodes of vomiting. Mr. s.22 saw his physician on June 6, 2016 and was diagnosed with a mild case of norovirus. Overall, he appeared stable and had no acute concerns. Tylenol and Gravol were prescribed for symptom control.

On June 7, 2016 at approximately 0115 hours, Mr. s.22 was found by staff standing in the corridor outside of his room, gazing out of the window. Staff assessed him and he seemed disoriented and was not responsive to staff members. Mr. s.22 vital signs were checked and his oxygen saturation levels were low. At 0200 hours, a decision was made to transport Mr. s.22 to the hospital for further assessment. Staff made arrangements for a forensic security officer to take Mr. s.22 to the hospital using their own ground transportation. At 0256 hours, Mr. s.22 went into cardiac arrest before he left the property. A code blue was called and CPR was initiated by staff members. 911 was called at 0258 hours. The BC Ambulance Service attended and took over resuscitative efforts. Mr. s.22 was transported to s.22 s.22 for treatment.

Mr. s.22 arrived at the hospital at 0357 hours, post-arrest. Resuscitation continued; however, Mr. s.22 arrested twice more in the trauma bay and his prognosis was poor. He was also found to have evidence of a gastro-intestinal bleed. Mr. s.22 was placed on comfort measures until his death at 0653 hours.

This investigation has identified a number of challenges that may have resulted in a delay in Mr. s.22 getting transferred to the hospital (prior to him going into cardiac arrest). It was reported that there were initial difficulties for staff reaching the doctor on call to obtain doctor's orders to send Mr. s.22 to the hospital. Furthermore, due to exposure with the norovirus, it was initially unclear as to which hospital would accept Mr. s.22 as a patient. It was reported that s.22 was the closest medical centre but they did not have any isolation beds available so declined the case unless it was emergent. It was reported that Surrey Memorial Hospital agreed to accept Mr. s.22 as a patient so staff arranged to transport him using their own ground transportation. 911 was not called until Mr. s.22 went into cardiac arrest and a code blue was called.

Colony Farms did a review of the circumstances and it was determined that a priority review be done of the paging system to make it easier to reach physicians on call as they are not on site after hours. The Code Blue Policy has also been updated so that 911 is called for any emergent health conditions and that the ambulance is specifically requested for attendance. Colony Farms also implemented changes to patient care plans to ensure that they are updated regularly with any medical status change in addition to mental health status charges.

BRITISH COLUMBIA

CORONER'S REPORT

INTO THE DEATH OF

s.22	s.22
SURNAME	GIVEN NAMES

POST MORTEM/TOXICOLOGY EXAMINATION

Post mortem examination revealed non-specific pulmonary congestion and edema. There was no evidence of significant natural disease, injuries or trauma. No anatomic cause of death was identified.

Toxicological analysis of ante-mortem (admission) blood and post-mortem specimens revealed the presence of clozapine at a potentially toxic level near the upper limit of the therapeutic range. Toxicology findings were otherwise unremarkable.

The pathologist concluded that the death was not likely due to clozapine overdose. However, clozapine, even at therapeutic dosages, is associated with an increased risk of sudden cardiac death, likely due to drug associated changes in the electrical rhythm of the heart (ie: prolonged QT interval). This may be a pre-disposing factor that may result in the development of a life-threatening cardiac dysrhythmia. Risk may increase with increasing drug dosages. The degree to which this may have caused or contributed to death cannot be demonstrated at autopsy and remains unclear.

CONCLUSION

I find that s.22 died in s.22 on June 7, 2016 of undetermined natural causes. Based on a totality of the evidence, it is reasonable to conclude that the death was a result of natural causes, although the exact mechanism could not be determined. I classify this death as natural. Given the actions taken from the Colony Farms Review, I make no further recommendations.

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Tara Louise Devine, Coroner
Province of British Columbia

Ministry of Justice
BC Coroners Service

Case No.: 2015-0376-0094

CORONER'S REPORT

INTO THE DEATH OF

s.22	s.22
SURNAME	GIVEN NAMES

OF

s.22

MUNICIPALITY OF RESIDENCE

I, Timothy Wiles, a Coroner in the Province of British Columbia, have investigated the death of the above named, which was reported to me on the s.22 and as a result of such investigation have determined the following facts and circumstances:

Gender:	☒ MALE ☐ FEMALE		
Age:	s.22 YEARS		
Death Premise:	HOSPITAL: PSYCHIATRIC		
Place/Municipality of Death:	s.22	Date of Death:	s.22
Municipality of Illness/Injury:	COQUITLAM	Time of Death:	0700 HOURS

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death:	a) Asphyxia
	DUE TO OR AS A CONSEQUENCE OF
Antecedent Cause if any:	b) s.15
	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:	Schizoaffective Disorder; Anti-Social Personality Traits; Polysubstance Disorder
BY WHAT MEANS	Self-Inflicted Injury

CLASSIFICATION OF DEATH ☐ ACCIDENTAL ☐ HOMICIDE ☐ NATURAL ☒ SUICIDE ☐ UNDETERMINED

Date Signed: OCTOBER 28, 2015

Timothy Wiles, Coroner
Province of British Columbia

This document has been prepared pursuant to the authority of the Chief Coroner, Coroners Act, S.B.C 2007 c.15 Section 53(2)

CORONER'S REPORT

INTO THE DEATH OF

SURNAME	GIVEN NAMES
s.22	s.22

INVESTIGATIVE FINDINGS

On s.22 the BC Coroners Service was notified of an in-patient death at Colony Farms Forensic Psychiatric Hospital. The decedent, identified as Mr. s.22 was discovered unresponsive in his room at 0615 hours. Nursing staff were alerted to Mr. s.22 room after the s.15 he was found s.15 s.15 which had been s.15 Staff moved Mr. s.22 to the floor of his room, determined him to be in cardio-pulmonary arrest and began resuscitation. Paramedics arrived at 0637 hours, however, efforts at resuscitation were unsuccessful and Mr. s.22 was pronounced deceased at 0700 hours.

On physical examination by the attending Coroner, Mr. s.22 was found lying supine on the floor. His clothing had been partially cut away by staff and evidence of medical intervention was noted. A s.15 was adjacent to the body. Prominent furrows were present on the anterior/lateral neck in a 'V' shape and were consistent with the material found. No defensive wounds, evidence of a struggle, or other overt indications of foul play were seen. A s.22 s.22 was present on Mr. s.22 right lower extremity, though this is unrelated to his cause of death. Inside the room, two hand-written notes with religious affirmations were found. Neither note made a clear statement of suicidal intent. The door to Mr. s.22 room was alarmed and in plain view of the nursing station.

Mr. s.22 was housed in a forensic unit that is deemed maximum security. Mr. s.22 was seen at 0407 hours by nursing staff that were monitoring the unit. At that time, Mr. s.22 was up using the shared washroom facilities and was found pacing the hallway. Nursing staff re-directed him back to bed without incident. A review of CCTV footage for the unit corroborates this report and shows Mr. s.22 entering his room for the last time at 0409 hours.

Mr. s.22 was seen by psychiatry on a weekly basis. His diagnoses included schizoaffective disorder, anti-social personality traits, and polysubstance use. There is a remote history of suicide attempt via s.22 This occurred while Mr. s.22 was residing in the community; the trigger for this event was the alleged commission of a criminal act. No acute change in his mental status was observed, though he had been acting out recently and was caught s.15 his medication on several occasions. Additionally, he was antagonizing a co-patient and had lost privileges for this. At the time of this incident Mr. s.22 was on 'general observation', though because of this recent interpersonal conflict with a co-patient, a nurse had elected to place him in an alarmed room. Mr. s.22 was well known to staff and had been housed in this facility on an intermittent basis for s.22

A concurrent criminal investigation was conducted and foul play was excluded.

BRITISH COLUMBIA

CORONER'S REPORT

INTO THE DEATH OF

SURNAME	GIVEN NAMES
s.22	s.22

POST MORTEM/TOXICOLOGY EXAMINATION

As cause of death was apparent upon physical examination at the scene, no further postmortem diagnostics were indicated.

CONCLUSION

I find that s.22 died in s.22 on s.22 of asphyxia due to s.15 I classify this death as suicide and make no recommendations.

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Timothy Wiles, Coroner
Province of British Columbia