



Report to the Minister of Justice and Attorney General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Court House in the City of Grande Prairie, in the Province of Alberta, on the 29 and 30 day of November, 2007, (and by adjournment on the 16 and 17 day of September, 2008), before James A. Watson, a Provincial Court Judge, into the death of Colleen Marie Akazay, 35 of Grimshaw, Alberta and the following findings were made:

Date and Time of Death: 9:30 a.m. to 10:00 a.m., February 18, 2006
Place: RCMP cells, Grande Prairie, Alberta Detachment

Medical Cause of Death: ("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization - The Fatality Inquiries Act, Section 1(d)).

A self induced overdose of prescription drugs and alcohol

Manner of Death: ("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable - The Fatality Inquiries Act, Section 1(h)).

Accidental

Circumstances under which Death occurred:

CHRONOLOGY OF EVENTS

Colleen Akazay and her common-law partner, Frank Ferguson, travelled by bus from Grimshaw, Alberta, to Grande Prairie, Alberta, on February 16, 2006.

On the evening of February 16, 2006, they stayed overnight at the Oasis church shelter.

Around 8:30 a.m., February 17, 2006, Colleen Akazay attended at the office of Dr. Wong, a dentist practicing at the time in Grande Prairie.

Dr. Wong, who was not previously familiar with Ms. Akazay extracted a tooth and repaired a crown following which he prepared a prescription for her which included ibuprofen and Tylenol 3s.

Ms. Akazay was observed in a local tavern at 4:00 p.m. that day. She was apparently intoxicated and was required to leave the premises. She later re-attended at around 9:00 p.m., staying until closing at approximately 2:30 a.m. Video surveillance at that time conveyed the impression that she was intoxicated.

Ms. Akazay was 35 years of age, approximately five feet tall and weighed approximately 260 lbs. Her medical history indicates that she was in poor health.

While at the Tavern, Ms. Akazay visited with a friend who confirmed that during the course of the evening Ms. Akazay became intoxicated. The friend noted that she observed Ms. Akazay occasionally sampling and consuming some powder substance out of a plastic bag.

Ms. Akazay requested her friend to permit her and Mr. Ferguson to stay with her overnight. Her friend did not grant that permission.

Shortly before 3:00 a.m., after leaving the tavern, Ms. Akazay and Mr. Ferguson again attended at the shelter, but were refused admittance. The shelter had a policy of refusing admittance after midnight.

Mr. Ferguson became upset and caused a disturbance. Employees of the shelter called the police.

Members of the RCMP responded to the complaint. Two police vehicles and three officers attended. One of the officers, Constable Pappas, was at the end of her shift and was about to go home when the call came.

Ms. Akazay and her companion were found outside the shelter. Ms. Akazay was sitting with her back to the shelter. Both presented with classic signs of alcohol intoxication and both smelled of alcohol.

The temperature was well below freezing. The Police determined that the two had no place to stay the night. Both were assisted to police vehicles and were able, with some assistance, to get up and walk to the vehicles.

Ms. Akazay and Mr. Ferguson were arrested for public intoxication and taken to the detachment.

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It was a busy night and one of the police vehicles responded to another call briefly before joining the other officer, Constable Pappas, who then took Ms. Akazay to the detachment.

At the detachment a number of other prisoners were being attended to and Constable Pappas had to wait before processing Ms. Akazay.

During this time, Constable Pappas, the arresting officer, had an opportunity to assess Ms. Akazay's condition.

Ms. Akazay (and her companion) presented as intoxicated. Ms. Akazay as drowsy but responsive and able to communicate. She was questioned about her drowsiness and responded that she had been up for almost 24 hours. She was able to walk unassisted to her cell.

In short, in appearance and condition, she was a representation of a very common sight in a busy and out of date detachment.

The detachment was old, cramped and busy. Within months it was replaced with a larger more modern facility.

Because of the busyness of the evening a number of officers participated in the booking-in process which included searching the prisoner and doing an inventory of personal effects.

Ms. Akazay's bag was searched and that search revealed a plastic bag containing a number of vials of prescription drugs in turn containing the drugs prescribed by Dr. Wong and other drugs prescribed by two doctors from Grimshaw, Drs. Botha and Louw.

Ms. Akazay and Mr. Ferguson were questioned about these drugs but abruptly became uncommunicative on this point.

As stated, more than one officer participated in the booking-in process and the C-13 form, detailing the information about the prisoner, was filled out by two officers.

Ms. Akazay was lodged in a cell occupied by another prisoner at 3:36 a.m. Constable Pappas stayed in the cell block area to further check the condition of Ms. Akazay for some time at least until 4:14 a.m. when she initialed her attendance on a log sheet for that purpose.

After using the facilities, during which she was observed by Constable Pappas, to button and unbutton her pants, she lay down on a cell cot and quickly fell asleep.

After falling asleep she began snoring heavily and within minutes, at 3:40 a.m., the person occupying the same cell complained about the noise and was moved to another cell. At this time as well, Ms. Akazay's condition was checked by Constable Pappas.

The snoring persisted for some considerable time and was noted by the guard, Elaine Hawryluk, who regularly monitored the condition of Ms. Akazay and other prisoners and noted same in the prisoner's lot book.

Later in the morning, at approximately 8:30 a.m., the Watch Commander, Sgt. Gear, reviewed the prisoners including Ms. Akazay, he noted no snoring at that time but was informed by other prisoners that she had been snoring loudly earlier.

Ms. Hawryluk was relieved by another guard, Patricia Brignall, at approximately 7:45 a.m. Together they did a walk through observing all of the prisoners. It was usual for the relieving guard to attend 15 minutes before the shift commenced so the previous guard could bring the successor up to date on any issues or matters of concern. It was usual as well, for the two guards to do a walk through together at this time.

LOG BOOK PROTOCOL

According to the RCMP policy, prisoners in RCMP custody are to be monitored regularly.

In Grande Prairie, a log book is kept for this purpose. Each person in custody is assigned a number and information pertaining to that prisoner is recorded, including the time of commencement of custody. The state of each prisoner is recorded regularly at approximate 15 minute intervals. After each prisoner is examined the guard is to check off that examination in an appropriate space and to record any observations pertaining to that prisoner and then to initial the actions completed.

From the time Ms. Akazay was lodged in cells, Ms. Hawryluk completed the log in accordance with procedure until 7:45 a.m. when she and the relieving guard Ms. Brignall did the walk through together. From 8:00 a.m. to 9:15 a.m. the log book was completed similarly. From 9:15 a.m. the guard's initials were not placed on the log.

At approximately 10:05 a.m., Watch Commander, Sgt. Gear, attended the cell area to supervise the process of the release of prisoners. Three prisoners were released and he then attended at the cell occupied by Ms. Akazay. He was accompanied by the guard whose responsibility it was to retrieve personal effects and return them to the prisoners. Presumably she accompanied Sgt. Gear from the point of his attendance in the cell area and performed tasks with respect to the prisoners dealt with earlier.

This may account for the absence of the initials on the log book from 10:00 a.m. to when Ms. Akazay's cell was entered.

Ms. Brignall testified that she noted a peculiar breathing pattern exhibited by Ms. Akazay at 10:30 a.m. This observation was not recorded in the log book, nor was it conveyed to Sgt. Gear or to any other RCMP member.

It was approximately 10:47 a.m. when Sgt. Gear reached Colleen Akazay's cell.

She was unresponsive and when Sgt. Gear entered the cell to examine her she was not breathing and had no pulse. Her lips were blue and her extremities were cold to the touch. She displayed lividity on the bottom of her arm and rigor mortis. To Sgt. Gear she was clearly deceased.

Members of the Grande Prairie Emergency medical services were called and arrived within minutes. Efforts at resuscitation were unsuccessful and abandoned and Colleen Akazay was confirmed dead.

An autopsy was performed on the body of the deceased under the direction of Dr. Graeme Dowling, Pathologist, and samples taken were forwarded for laboratory analysis supervised by Dr. Graham Jones, Chief toxicologist for the Office of the Medical Examiner for the Province of Alberta.

Pursuant to that analysis the presence of alcohol, cocaine and a number of drugs, notably including codeine and bromazepam was detected.

Codeine is a major constituent of Tylenol.

Tylenol and bromazepam in some quantity were found in the powdery substances and vials of tablets seized from the personal effects of Colleen Akazay.

The vials of drugs were from prescriptions authorized by three different professionals: Drs. Botha, Louw, and Wong.

Dr. Jones indicated that the amount of codeine in Colleen Akazay's body was at a level which was toxic and potentially life threatening.

Bromazepam was present in an amount indicating abuse or over consumption and while in an amount not toxic, its effect would be to enhance the effect of codeine and alcohol present.

Dr. Jones stated that the concentration of alcohol, codeine, and bromazepam present in Ms. Akazay were sufficient to cause her death.

Drs. Botha and Louw were general practitioners whose practices were based in Grimshaw, Alberta. They practiced out of the same clinic. As a general rule prescriptions made by them, from that clinic were filled from a pharmacy also located in Grimshaw. Dr. Wong, a dentist, practicing in Grande Prairie attended to Colleen Akazay earlier on the date of her death.

Dr. Botha was Ms. Akazay's doctor from 1997 and from that date was her primary medical care giver. He treated Ms. Akazay for a variety of ailments including, chronic backache, chronic depression and anxiety and stress. His treatment included prescribing various drugs which included Tylenol and bromazepam.

From time to time other doctors from the clinic also prescribed drugs for Ms. Akazay. At times in the years leading up to her death Ms. Akazay received prescriptions in amounts in excess of recommended therapeutic dosages.

On at least two occasions prescriptions were renewed after Ms. Akazay advised her doctor that the prescription had been lost or stolen.

Ms. Akazay was receiving prescriptions from other doctors or obtaining over the counter non-prescription Tylenol without her doctors knowledge.

High Prairie medical records indicate that Mr. Akazay was hospitalized twice in that area for suspected drug over doses.

Comparing records from the Grimshaw clinic and the pharmacy on at least two occasions the amount of the prescription filled exceeded the amount shown in the clinic file. If both records are accurate it suggests the prescription was altered or that another prescription was filled. Either case is consistent with prescription drug abuse.

Clearly over time Dr. Botha recognized that Ms. Akazay had a long standing alcohol problem. Clearly she was abusing prescription drugs. Clearly she had been counseled about the dangers of combining alcohol and drugs especially drugs containing codeine and bromazepam. She did not follow that advice.

Colleen Akazay was an unhappy, unhealthy, overweight person who had acquired a prescription drug dependency and had a serious alcohol problem. Sadly her destructive lifestyle led to her unfortunate end.

Recommendations for the prevention of similar deaths:

Colleen Akazay died in the RCMP detachment cells in Grande Prairie, Alberta, from a deadly combination of alcohol and prescription drugs.

This inquiry in part is to determine the circumstances of her death and to make such recommendations that might go toward preventing future such occurrences.

The detachment has changed significantly since February 18, 2006. A new facility replaced the older one within months of her death and besides the newer building, procedural changes relative to the admission of prisoners has replaced those existing previously.

Some of these changes include a replacement assessment procedure to better determine the responsiveness of the prisoner and a directive concerning the advisability of medical attention for those prisoners who are suspected of being under the influence of a combination of alcohol and drugs.

Physical inspection of prisoners has been changed to provide for more supervision by senior officers.

The installation of closed circuit television for each cell exists in the new facility.

These and other changes have to a great degree addressed any concerns that might have been directed to the facility or the prisoner's protocol previously existing.

This unfortunate individual led an unhealthy self-destructive lifestyle culminating in her death from a combination of alcohol and prescription drugs.

Her access to the latter was, if not facilitated, not impeded by a system in which she was able to obtain and stock-pile those drugs. She was able to access more than one doctor for the purpose of obtaining prescriptions.

It is recommended that consideration be given to the establishment of a registry whereby those professionals who have the responsibility to prescribe and dispense potentially dangerous prescription drugs can access information pertaining to prior prescription drug access.

DATED September 21, 2009 ,

at Grande Prairie , Alberta.

Original signed by

James A. Watson
A Judge of the Provincial Court of Alberta