Presiding Coroner's comments:

Background

The inquest took place in Whitehorse between April 8 and April 25, 2024. The inquest reviewed the deaths of four First Nations women, Cassandra Warville, Myranda Aleisha Dawn Tizya-Charlie, Josephine Elizabeth Vanessa Hager and Darla Skookum who died at the Whitehorse Emergency Shelter over a 15 month period between January 2022 and April 2023, while accessing services at the shelter. In addition to Coroner's counsel, participant standing was granted to the Council of Yukon First Nations, the family of Darla Skookum, the Little Salmon Carmacks First Nation, the Vuntut Gwitchin First Nation, the Selkirk First Nation, the Department of Health and Social Services of the Yukon Government and Connective Support Society ("Connective"). The inquest heard from family members, representatives and friends and thirty-five witnesses, some of whom testified about more than one of the deaths. Witnesses included shelter guests, Yukon Government and Connective shelter frontline staff, shelter managers and shelter administrators, Yukon Government administrators responsible for the shelter contract, paramedics, RCMP, an emergency room physician, a pathologist, a toxicologist and people with expertise in running and evaluating harm reduction and low barrier programs.

The Whitehorse Emergency Shelter is located at 405 Alexander Street. The Yukon Government assumed responsibility for the shelter in January 2019 relaunching it as a low barrier shelter which it ran until September 2022. Connective took over operations of the Whitehorse Emergency Shelter on October 1, 2022 and has operated it since that date under a funding agreement with the Yukon Government. The Department of Health and Social Services oversees this agreement. Under the agreement, Connective also operates a drop-in program, a meal program and a housing first program at 405 Alexander Street. The Yukon Government began an onsite paramedic specialist program in 2019 which was expanded with the goal of providing 24-hour service by May 2024. The majority of the people using the shelter are First Nations. Witnesses testified that most of the people accessing services at the shelter regularly engage in substance use.

In 2022, the Yukon Government contracted with Vink Consulting and the House of Wolf & Associates to conduct independent evaluations on safety and wellness issues connected to the Whitehorse Emergency Shelter and the surrounding neighbourhoods. The reports were both released in the spring of 2023.

The Jury's Findings

Thirty-five year old Cassandra Warville, a member of the Vuntut Gwitchin First Nation, died at 405 Alexander Street on the 18th or 19th day of January 2022 sometime between 11:30pm and 3:25am as a result of complications of alcohol and fentanyl intoxication with cocaine use as a contributing factor. The jury classified her death as accidental.

Thirty-four year old Myranda Aleisha Dawn Tizya-Charlie, a member of the Vuntut Gwitchin First Nation, died at 405 Alexander Street on the 19th day of January 2022 sometime between

3:15am and 3:25am as a result of complications of combined alcohol and drug intoxication with cocaine use as a contributing factor. The jury classified her death as accidental.

On January 18, 2022, Cassandra Warville and Myranda Tizya-Charlie were staying in the women's overflow section of the Whitehorse Emergency Shelter. Staff testified that they had been in and out of the shelter that evening. At just after 11:15pm, video evidence showed a staff member (staff member 1) unlocking the women's shower room to let Cassandra Warville and Myranda Tizya-Charlie in. This was a single use washroom with a toilet and shower. About 10 minutes later, two shelter users knocked on the shower room door. There was no answer and the shelter guests left.

At approximately 2:56am on January 19, 2023, staff member 1 noticed the shower room door was locked. Staff member 1 entered the shower room and discovered Cassandra Warville slouched on the toilet seat and Myranda Tizya-Charlie on the floor. Staff member 1 conducted a pain stimulus on each of the women with no response and checked for a pulse and breathing but detected neither. Staff member 1 testified that he administered nasal naloxone to Cassandra Warville in the shower room. Staff member 1 then left the shower room and alerted a second staff member (staff member 2) to call EMS with what he suspected were overdoses. Staff member 2 returned to the front desk to use a landline to call 911. The dispatcher went over CPR and the use of an AED with staff member 2. Staff member 1 then appeared to radio another staff member (staff member 3) who was on break on the third floor. Staff member 1 returned to the shower room and dragged Myranda Tizya-Charlie from the shower room to the front lobby area. Staff member 1 then returned to the shower room and dragged Cassandra Warville to the lobby area. Staff member 1 began CPR on Cassandra Warville. Staff member 3 arrived and began CPR on Myranda Tizya-Charlie. Staff member 2 handed a naloxone kit to a shelter guest and shortly after another naloxone kit to a second shelter guest. Staff member 2 testified that he did not intend for the shelter guests to prepare the naloxone syringes. Shortly after staff member 2 handed the naloxone kits to the shelter guests they attempted but failed to prepare them. Staff member 2 took the AED from behind the front desk and placed it on the counter. Staff member 1 retrieved the AED and hooked it up to Cassandra Warville and it advised "no shock" and to continue with CPR. Staff believed that there was a second AED on the second floor of the shelter, but it was not retrieved.

Paramedics arrived at 3:05am, the RCMP arrived shortly after, and firefighters arrived a few minutes later. Emergency responders continued life saving measures. The critical care paramedic pronounced Cassandra Warville's death at 3:25am. The critical care paramedic testified that no signs of life were ever observed for Cassandra Warville while first responders attended. The critical care paramedic described Myranda Tizya-Charlie's condition as critically unwell when first responders arrived. The critical care paramedic testified that Myranda Tizya-Charlie's heart arrested at 3:15am and despite continued life saving attempts following critical care protocols, no signs of life returned, and she was pronounced dead at 3:25am on January 19, 2022.

After letting Cassandra Warville and Myranda Tizya-Charlie into the shower room, no staff checked on them for the next 3 ½ hours. At the time of their death, there was no written policy, guideline or directive or standard practice regarding conducting regular checks of the multiuse washrooms, shower rooms or other high risk areas at the shelter.

Thirty-eight year old Josephine Elizabeth Vanessa Hager, a member of the Selkirk First Nation, died at 405 Alexander Street on the 1st day of February 2023 sometime between 4:35am and 5:00am as a result of combined morphine and alcohol toxicity with gabapentin use, renal fibrosis and fatty liver disease as contributing factors. The jury classified her death as accidental.

At the time of her death, Josephine Hager was residing in permanent housing at 405 Alexander Street. In the 2 months prior to her death, EMS was called in response to a complaint that she overdosed on pills; she was sexually assaulted by a male resident on December 6, 2022; and she expressed suicide ideation which may also have been connected to the recent deaths of a number of family members. Although the manger of the shelter had drafted a safety plan for her at some point following the assault, it was never communicated to the staff or implemented.

On February 1, 2023, video evidence showed Josephine Hager outside in the smoking area in the early morning hours. She appeared to be unsteady on her feet. At 3:48am, she was pushed from the smoking area into the dining area in a wheelchair by another shelter guest because she was unable to walk on her own. A shelter staff (program coordinator) observed this and radioed other shelter staff to keep an eye on her. Josephine Hager spent the next half hour seated at a table with other shelter guests with her head on the table for most of the time. No staff approached her.

The video evidence showed Josephine Hager stumbling in the shelter corridor at 4:21am, using the wall to keep her balance. At 4:22am, Josephine Hager can be seen sitting in the doorway to the smoking area with her knees to her chest. A staff member (staff member 4) briefly spoke to her. At approximately 4:24am, Josephine Hager can be seen falling from her kneeling position onto her back in the hallway. Staff and shelter guests walked by her while she is lying on the ground. Staff member 2 appeared to touch Josephine Hager on the arm, left and returned at 4:26am when he appeared to apply a pain stimulus and left again. At 4:28am, a shelter guest and staff members 2 and 4 interacted with Josephine Hager. Staff member 2 again applied a pain stimulus. The shelter guest tried unsuccessfully to help her up. At 4:29am, the program coordinator checked on her and a shelter guest helped her to a sitting position. At 4:32am Josephine Hager can be seen lying on her back in the hallway not moving. At 4:40am, staff member 2 passed near Josephine Hager but did not interact with her. At 4:41am, a shelter guest checked on her and gestured to staff. Staff member 2 returned and appeared to apply a pain stimulus but Josephine Hager remained motionless and staff member 2 left. At 4:42am, staff member 2 applied a pain stimulus and together with a shelter guest raised Joesphine Hager to a sitting position. The shelter guest appeared to rub her chest and then laid her back down. Staff member 2 left.

At 4:43am, shelter guests began looking for a pulse and then began chest compressions. Staff member 4 arrived and injected Josephine Hager with Naloxone and took over the chest compressions. An RMCP officer arrived and took over chest compressions. The program coordinator gave an airway mask to the RCMP officer who began giving Josephine Hager breaths. Staff member 4 administered more Naloxone and chest compressions and breaths continued. Another RCMP officer arrived and hooked up an AED. The AED advised "no shock" and to continue with CPR. EMS arrived at 4:51am and firefighters at 4:53am. Paramedics and firefighters took over CPR. The paramedic testified that a decision was made to transport Josephine Hager to the hospital as the paramedic had no advanced life support available. At 5:14am, Josephine Hager was placed on a stretcher and CPR continued as she was placed in an ambulance at 5:16am. The paramedic testified that no signs of life were ever detected by

first responders. The emergency doctor at the hospital confirmed that there were no signs of life and pronounced her death.

The jury heard evidence that it was not unusual for Josephine Hager and occasionally, other shelter guests to lie on the floor in the hallways or common areas. The inquest heard evidence that there were no policies, procedures or directives with guidance on determining who was beyond the level of care of the staff and when it was appropriate for staff to call EMS.

Fifty-two year old Darla Skookum, a member of the Little Salmon Carmacks First Nation, died at 405 Alexander Street, on the 16th or 17th day of April, 2023 sometime between 9:45pm and 6:00am as a result of acute alcohol toxicity with cirrhosis of the liver, fatty liver disease, nephrosclerosis of the kidneys, chronic alcohol abuse disorder, hepatitis C, cocaine, hydromorphone use and being positioned on her stomach as contributing factors. The jury classified her death as accidental.

Darla Skookum was known to Whitehorse Emergency Shelter staff as a heavy consumer of alcohol. Staff reported assisting Darla Skookum to bed on a number of previous occasions due to alcohol intoxication.

Darla Skookum was staying at the Whitehorse Emergency Shelter on April 15, 2023. Video evidence showed Darla Skookum in the shelter lounge with several other shelter guests around 7:00pm. At times, Darla Skookum placed a jacket over her head and appeared to be sleeping. At 9:28pm, a shelter guest approached Darla Skookum and was able to wake her. At 9:29pm, Darla Skookum appeared to be unconscious again. At 9:37pm, a staff member (staff member 5) attempted to wake Darla Skookum and then left. A shelter guest attempted to have Darla Skookum stand but she fell down. Darla Skookum was left in a seated position on the floor and at 9:40pm, staff member 5 returned with a wheelchair. At 9:41pm, staff member 5 and three shelter guests lifted Darla Skookum into the wheelchair while a fourth shelter guest held the wheelchair. Darla Skookum did not appear to be conscious. Staff member 5 wheeled Darla Skookum to the women's overflow sleep area. At 9:45pm, staff member 5 and staff member 3 moved Darla Skookum's legs onto a mat, picked her up and leaned her forward onto the mat. She was placed on her stomach on the mat with her head face down on a pillow. Another staff member (staff member 6) held the wheelchair while the other staff moved Darla Skookum onto the mat. Staff member 3 removed Darla Skookum's boots. Staff testified that they moved her head to the side so she could breathe but the video showed Darla Skookum face down on the pillow when the staff left the room at 9:46pm.

After the shelter staff left the room, a shelter guest sleeping in the overflow room covered Darla Skookum with a blanket. Several shelter guests came and went from the overflow room throughout the night, but Darla Skookum remained motionless. At 12:22am on April 16, a staff member (staff member 7) entered the overflow room and gave a shelter guest a blanket but did not approach or check on Darla Skookum. At 1:36am, staff member 7 entered the overflow room and placed a bin on a counter near Darla Skookum but did not interact with or check on her. At 1:46am, staff member 7 returned to the overflow room and placed a blanket on a mat next to Darla Skookum and then moved the blanket to another mat. Staff member 7 did not interact with or check on Darla Skookum and left the room at 1:48am. At 3:22am, staff member 5 accompanied a shelter guest to the overflow room and left. At 7:27am, staff member 5 let a shelter guest into the overflow room.

At 10:07am, shelter staff (staff member 8) arrived in the overflow room and woke the three other women sleeping in the overflow room, then approached Darla Skookum. He placed his hand on her back to wake her. Staff member 8 then left the room and returned a minute later with the onsite paramedic. The paramedic rolled Darla Skookum onto her back and then left and returned with medical equipment and began an assessment. The paramedic testified that Darla Skookum was stiff with rigour mortis, and he believed that she was deceased. The paramedic utilized an AED to obtain vital signs which confirmed there were no signs of life. Video evidence showed that from the time staff left Darla Skookum in the overflow area at 9:46pm until shelter staff 8 attempted to wake her at 10:07am the following day, Darla Skookum did not move, and no staff checked on her.

The inquest heard evidence that staff commonly put individuals who are not ambulatory or have compromised levels of consciousness due to substance use in bed with the use of a wheelchair. At the time of the deaths, there were no written policies, procedures or directives or standard practices regarding conducting checks of dormitories, the overflow room or persons in compromised conditions when they were placed in bed.

The Jury's Recommendations

Recommendation #1 – Policy Review

A policy review for the Whitehorse Emergency Shelter will be undertaken by Connective Support Society within six months that:

- *Includes interested Yukon First Nations, shelter guests, shelter staff and people with lived experience in the review, development and implementation of policy, procedures and guidelines*
- *Ensures the development of policies, procedures and guidelines are evidence based, best practice and data driven (measurable)*
- *Ensures that policies, procedures and guidelines provide clear direction to staff in carrying out their responsibilities*
- *Reduces the gaps between current policies and current shelter practices*
- *Provides clarity to shelter guests around expectations of guests and the level of services provided by the Whitehorse Emergency Shelter*
- *Gives priority to reviewing policies, procedures and guidelines related to:*
    - *Identifying when guests are beyond the level of care manageable by staff*
    - *Safety planning for shelter guests*
    - *When to involve EMS*
    - *Lifting procedures*
    - *Dealing with intoxicated/medically vulnerable guests*
    - *Overdose events and medical emergencies*
    - *Monitoring vulnerable guests*
    - *Monitoring high risk spaces e.g., washrooms, showers*
        - *Making naloxone easily and readily available in these spaces*
    - *Culturally appropriate services and cultural safety*

- *Trauma informed practice*
- *Harm reduction*
- *Critical incident review, reporting and sharing of information*
  - *All employees involved in a critical incident complete a report*
- *Video review and retention for critical incidents*
- *Performance development and management*

The jury heard testimony from shelter staff, managers and program administrators that policies, practices and procedures were not always; clearly laid out, understood by staff, reviewed on a regular basis, or enforced. They also did not always provide clear direction or guidance. This was specifically evident in the priority areas identified in the above recommendation. In the absence of clarity, direction and enforcement, staff were often left to their own judgement and discretion. The jury further heard testimony from witnesses with expertise in harm reduction and evaluation of low barrier services, about the importance of having consistent and enforced policies, procedures and practices to ensure safety and clear expectations for both staff and shelter guests. The jury additionally heard testimony on the importance of involving interested First Nations, staff, shelter guests and people with lived experience in the development of policy, procedures and practices to ensure that they meet the needs of those accessing services.

The inquest also heard testimony about the need for better information sharing among staff to ensure all staff are aware of any significant incidents that may have arisen, safety planning that needs to be implemented or maintained, or additional monitoring or support that shelter guests may require. The inquest also heard of the importance of proper reporting and information gathering following critical incidents to ensure that lessons are learned and shared with staff, policies are reviewed, and appropriate resources and training are identified to address any gaps.

Recommendation # 2 – Training Review

Within six months, Connective Support Society in conjunction with interested Yukon First Nations, shelter guests, staff and other support services, will research and adopt a training plan assessing current training needs, based on best practices, that addresses both onboarding, orientation and ongoing professional development giving initial priority to:

- *Shelter policies, procedures and guidelines will be accessible (simplified) and reviewed frequently*
- *Overdose response training*
- *Identifying alcohol intoxication and managing related safety risks*
- *Identifying when shelter user needs exceed the level of service provided by the shelter and actions to be taken*
- *Providing regular drills and performance feedback concerning emergency response within the shelter e.g.; overdose response, 911, medical distress, naloxone administration*
- *Reviewing staff first aid and naloxone requirements and frequency, including basic life support and airway management (use of oxygen and oximeter), with a first aid training provider (in consultation with Whitehorse EMS) to ensure first aid skills*

match the needs of shelter guests within the level of service provided by the Whitehorse Emergency Shelter

- *Culturally appropriate services and cultural safety*
- *Trauma informed practice*
- *Harm reduction*
- *Ensuring program managers have the skills to*
  - *enforce the consistent application of policy among all staff*
  - *conduct effective post critical incident debriefing to maximize lessons learned and staff performance*
- *Make Naloxone training and Standard First Aid – CPR available to service users*

The jury heard testimony from staff, managers and program administrators about staff training primarily happening at the onboarding stage with little ongoing professional development. A number of witnesses identified gaps in training including sufficient training with respect to cultural awareness and safety, trauma informed practice, dealing with intoxicated shelter guests, how to recognize when a shelter guest's needs where beyond the level of care provided by the shelter and when and how to engage other services such as EMS, the RCMP or Adult Protection Services. The jury also heard testimony that additional training on how to implement existing policies, procedures and practices was needed including their enforcement. Additional training was also needed on performance management by managers and administrators.

In addition, the jury heard testimony from witnesses with expertise in harm reduction and evaluating low barrier services on the importance of involving interested First Nations, staff and shelter guests in the development and delivery of training. The jury heard evidence that staff are required to have standard First Aid training as a prerequisite for working at the shelter which does not address many of the types of scenarios they are likely to encounter at the shelter. Witness testimony covered the importance of ensuring staff have sufficient training in First Aid, overdose response and dealing with shelter guests in medical distress to meet the needs of shelter guests who are provided services at the shelter. Finally, the importance of practicing skills on an ongoing basis through practice scenarios and drills was highlighted in testimony.

Recommendation #3 – Staffing Priorities

Immediately, Connective Support Society will give priority to hiring Indigenous employees and persons with lived experience when posting positions for the Whitehorse Emergency Shelter. Additionally, Connective Support Society will work with interested Yukon First Nations to identify ways to attract, support and retain Indigenous employees.

The jury heard testimony from shelter guests and witnesses with expertise in harm reduction and the evaluation of low barrier services on the importance of service providers reflecting the people accessing services. The jury also heard testimony on the necessity of having Indigenous staff in order to provide culturally appropriate and culturally safe services for Indigenous shelter guests.

Recommendation #4 - Evaluation

In six months, the Yukon Government, through its Transfer Payment Agreement provisions, will evaluate Connective Support Society for compliance with recommendations 1, 2 and 3.

The jury heard evidence that the Yukon Government has the responsibility to ensure that Connective is delivering the programs and services identified within the Transfer Payment Agreement.

Recommendation #5 – Independent Review

> *If future deaths should occur at the Whitehorse Emergency Shelter, the Yukon Government will work with the Connective Support Society to ensure an independent review.*

The jury heard evidence that Whitehorse Emergency Shelter managers and administrators undertook minimum to no review of the deaths of Cassandra Warville, Myranda Tizya-Charlie, Josephine Hager and Darla Skookum in terms of identifying the facts and circumstances surrounding the deaths, incident reporting, staff debriefings, a policy and practices review, performance reviews and reports to funder, in order to learn from the tragedies and improve practices moving forward. The jury also heard that the Yukon Government received minimal reporting related to the last two deaths, did not request further information and took no further action in relation to these deaths.

Recommendation #6 – Grief and Loss

> *In recognition of the grief and loss in the Whitehorse Emergency Shelter community, within two months, leadership from the Government of Yukon and Connective Support Society will meet with the community affected by the deaths of Myranda Tizya-Charlie, Cassandra Warville, Josephine Hager and Darla Skookum to hear their concerns arising from the inquest.*
>
> *Within six months, Connective Support Society, will provide access to in-person counselling for all staff as needed.*

The jury heard testimony about the impact, including the trauma, the deaths of shelter guests can have on other shelter guests, the families and communities, and the staff.

Recommendation #7 – Communication

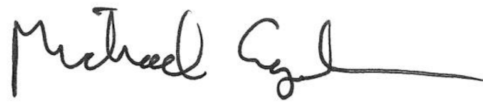
> *Immediately, Connective Support Society in consultation with interested First Nations will begin a monthly talking circle and a structured complaint process (e.g. complaint box) to nurture trusting relationships and contribute to a welcoming environment.*
>
> *Connective Support Society will improve communication among staff by formalizing the pre and post briefings of all shift exchanges.*

The jury heard evidence from witnesses with expertise in harm reduction programs that establishing relationships of trust is central to providing service to shelter guests. The jury heard further testimony on the importance of shelter guests' voices being heard to ensure that the services being provided are meeting their needs in culturally appropriate and culturally safe ways.

Recommendation #8 – Safe Spaces

> *In recognition of the safety concerns of LGBTQ2S+ and female identifying services users Connective Support Society will, within the next 6 months, identify and create safe space for their use.*

The jury heard testimony from witnesses with expertise in harm reduction and the evaluation of low barrier services, that low barrier services can create additional safety issues for LGBTQ2S+ and female identifying shelter guests and the importance of creating safe spaces for them.



Presiding Coroner Michael Egilson