CORONER'S REPORT

INTO THE DEATH OF

WESTERVELT	ARLENE SUSAN
Surname	Given Names

I, CAROLYN MAXWELL, a Coroner in the Province of British Columbia, have investigated this death which was reported 27-Jun-2016 and determined the following facts and circumstances:

AGE:	56	**PLACE OF DEATH:**	LAKE COUNTRY
DATE OF DEATH:	26-Jun-2016	**PREMISES OF DEATH:**	Body of Water

Medical Cause of Death:

(1) Immediate Cause of Death:	a) Undetermined
	due to, or a consequence of
Antecedent Cause if any:	b)
	due to, or a consequence of
Giving rise to the immediate cause (a) above, stating underlying cause last:	c)

(2) Other Significant Conditions Contributing to Death:

POSTMORTEM EXAMINATIONS:	Y	**TOXICOLOGY:**	Y
CLASSIFICATION OF DEATH:	Undetermined		

Dated 9 of February, 2023 and electronically signed by:

CAROLYN MAXWELL, 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 S. 16, S. 69
https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/07015_01

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Circumstances:

The death of Arlene Susan Westervelt was reported to the BC Coroners Service by Lake Country RCMP on June 27, 2016. Arlene Westervelt's body had been recovered from Lake Okanagan by a RCMP underwater recovery team after she was reported missing following a canoeing incident the previous day. She was recovered approximately 30 meters from shore, at a depth of approximately 12 metres.

RCMP advised the attending coroner that Mrs. Westervelt and her spouse had been canoeing together on Okanagan Lake the previous day, June 26, 2016, when, at approximately 1920 hours, in daylight hours, the canoe capsized, throwing both into the lake. Occupants of a nearby pleasure boat, one of whom had observed the canoe capsizing, assisted Mrs. Westervelt's spouse into their boat. Mrs. Westervelt could not be located despite searches by one of the boaters who stopped to assist and first responders called to the scene.

The attending coroner authorized transfer of Mrs. Westervelt to hospital where the coroner completed an external examination, including photos. No signs of external injury or trauma were noted during the examination.

Investigative Findings:

A statement from Mrs. Westervelt's spouse had been obtained by RCMP following the canoe capsizing on June 26th. Her spouse had relayed that he and Mrs. Westervelt had gone out in their canoe earlier that day. Part way through the day, they noticed an area on shore that would be a good place for a picnic. They returned home to gather items for a meal and then headed back to the lake and set off in their canoe towards this picnic spot. Mrs. Westervelt's spouse stated that, following their picnic, they loaded up the canoe and headed back out on the lake to return home. He stated that he was in the stern of the canoe and Mrs. Westervelt was in the bow. He stated that they had life jackets with them in the canoe, but they did not wear them on this return trip. Once they were in the canoe, they maneuvered the canoe in a large loop so that it would be facing North, towards where their vehicle was parked.

The statement advised that, once they were in the canoe, Mrs. Westervelt appeared to reach behind her for something and the canoe moved suddenly to the left. They both overcompensated to the right and the canoe capsized. Once in the water he told Mrs. Westervelt to hold on to the canoe and he then reached under the canoe to look for a life jacket. When he came back, she was not there, and he did not see her again.

Occupants of a motorized pleasure boat on the lake the evening of June 26, 2016, also provided a statement to RCMP. They reported that, at approximately 1920 hours on June 26th, they had been travelling northbound at a slow rate of speed. One of the passengers on the boat noticed a canoe close to shore, approximately 150 – 200 meters away from

CORONER'S REPORT

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their boat and about 30 meters from shore. The passenger alerted the operator of their boat so that they could keep a safe distance from the canoe. The passenger of the pleasure boat watched the canoe turn in a northerly direction. While watching the canoe, the passenger saw it suddenly flip over. The passenger noted that the water was calm, and they did not see anyone standing up in the canoe immediately prior to it overturning.

Unsure whether the canoe occupants needed assistance, the pleasure boat headed slowly towards the overturned canoe and as it got closer, the passenger could see a person in the water who appeared to be thrashing around. As they got even closer they could see that the person in the water was a male and that he appeared to be moving from one side of the canoe to the other. Once the boat was close enough that they could call out, they asked the man if he was okay, and he responded that he could not find his wife. The occupants of the pleasure boat assisted the man onto their boat and called 911 at approximately 1929 hours. One of the occupants of the boat entered the water and began diving in search of the man's wife. First responders arrived on scene and took over the search efforts, until they had to be called off due to darkness. RCMP confirmed that the canoe seen by the independent witnesses was the one used by Mrs. Westervelt and her spouse and that the man in the water was Mrs. Westervelt's spouse. Mrs. Westervelt was recovered from the lake the following day, June 27, 2016, by a RCMP underwater recover team.

Police stated that there was no reported history of violence between Mrs. Westervelt and her spouse and expressed no concerns about foul play. As all available evidence supported Mrs. Westervelt's death as accidental, the coroner determined that an autopsy was not necessary. Mrs. Westervelt's body was released on June 29, 2016, for funeral arrangements.

In the days following, individuals came forward and expressed concerns regarding the relationship between Mrs. Westervelt and her spouse and it was learned that she had recently sought legal advice with respect to divorce. In light of this new information, the BC Coroners Service regained possession of Mrs. Westervelt's body and directed a forensic autopsy.

Post Mortem Findings:

The forensic autopsy was conducted on July 6, 2016. The pathologist noted that the body had been embalmed prior to autopsy. Embalming is a procedure routinely undertaken by funeral homes to preserve a body and slow down decomposition. The autopsy revealed hemorrhages on the anterior and posterior surfaces of the strap muscles of the neck, although marks on the skin of the neck were not identified. The pathologist observed that the soft tissues of the neck were not affected by the embalming process. There were bilateral scleral hemorrhages evident (without scleral or periorbital petechiae). The pathologist noted that photographs taken pre-embalming at hospital by the coroner showed no obvious scleral hemorrhages and no convincing evidence of scleral or periorbital petechiae. There was a small bruise

CORONER'S REPORT

INTO THE DEATH OF

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on the upper lip indicative of some minor facial trauma but its significance was uncertain. There were no marks on the skin of the neck, no injury to the pharynx or larynx (this would include the hyoid bone as it sits between the two) and no petechiae in or around the eyes. Examination of the heart showed left ventricular hypertrophy. It was noted that, given that Mrs. Westervelt's death occurred in water, drowning could not be excluded as a possible cause of death.

Toxicology testing revealed the presence of a medication prescribed to Mrs. Westervelt at a possible supratherapeutic but non-toxic level. Additional toxicology testing performed at the RCMP laboratory confirmed these findings.

As autopsy findings were not definitive for a cause of death, the pathologist's report concluded that the cause of death was undetermined. A copy of the report was provided to the RCMP on February 9, 2017.

Additional Investigative Findings:

On July 19, 2016, Mrs. Westervelt's spouse provided another statement to police in which he relayed the same information regarding the moments leading up to the canoe capsizing as provided in his June 26, 2016 statement. However, in the new statement he advised that, once they were in the water and he came to the surface, he could see that Mrs. Westervelt was horizonal in the water with her foot up on the bow of the overturned canoe, with her head at the surface of the water. He stated that he felt the canoe might tip so he moved her foot off the bow. Mrs. Westervelt then went under the water. He grabbed her arm but she pulled out of his grip. He then reached under the water and was able to pull her up to a point where her arm was partially out of the water. He felt Mrs. Westervelt strike out with either a hand or a foot and hit him in the shoulder. He lost his grip on her and she then went under the water and he did not see her again.

In June 2019, another BC Coroners Service Post Mortem Diagnostic Service forensic pathologist undertook a cardiovascular pathology consultation for the purpose of providing additional expert assessment of autopsy findings. This pathologist reviewed the original autopsy report and histology slides obtained during the autopsy and confirmed the finding of significant left ventricular hypertrophy.

The consult report noted that left ventricular hypertrophy can be caused by hypertension or by genetic heart diseases and can cause sudden collapse or seizure-like activity. The results of the cardiovascular pathology consultation were provided to RCMP on June 12, 2019.

Upon concluding her investigation, the investigating coroner determined that there were three competing causes of death and none were more likely than the others. The cause and manner of Mrs. Westervelt's death were ruled undetermined.

CORONER'S REPORT

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On May 12, 2021, a team of forensic pathologists from the BC Coroners Service Post Mortem Diagnostic Service reviewed the findings of the original pathologist. The review concurred with the conclusion of an undetermined cause of death.

Concerns continued to be expressed by members of Mrs. Westervelt's family and the public regarding the circumstances surrounding her death. On April 19, 2022, the Chief Coroner directed that the investigation into Mrs. Westervelt's death be re-opened to ensure that the BC Coroners Service had undertaken everything within its authority to determine the cause and manner of death. Neither the original investigating coroner nor the pathologist who conducted the original autopsy were involved in the new investigation.

All investigative materials and evidence gathered during the original investigation were reviewed. Despite concerns and allegations raised in the community, no new evidence was submitted.

At the request of the BC Coroners Service, the Ontario Forensic Pathology Service convened a Complex Case Expert Committee (CCEC) on August 16, 2022, to review the case of Arlene Westervelt. The review was conducted by a panel of five forensic pathologists and doctor with expertise in post mortem imaging ("the panel") from across Canada. Three of the panel members are members of the CCEC, which is a rotating group of forensic pathologists who review and lend their expertise to complex cases across Canada. The participating members are determined on a rotational basis, and the requesting jurisdiction cannot influence which members of the group will be conducting the requested review. Two additional senior forensic pathologists and a physician managing postmortem imaging with a provincial forensic pathology unit also participated in the review, with each selected based on their extensive expertise in forensic pathology and imaging in various Canadian jurisdictions. The review did not include the pathologist who conducted the initial autopsy, the cardiovascular pathology consultant or any BC Coroners Service employee, including members of the BC Coroners Service Post Mortem Diagnostic Service team.

The CCEC panel reviewed the following material:

1. Final Report of Post Mortem Examination
2. Coroner's Report
3. Cardiovascular pathology Report
4. Toxicology Report
5. Autopsy and scene photographs

The panel agreed that it would have been advantageous if the post mortem examination had been completed immediately after the death as the delay and the embalming procedure could have compromised signs of drowning and introduced

CORONER'S REPORT

INTO THE DEATH OF

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artifacts within the body, including in the soft tissues of the neck. Current BC Coroners Service policy requires that an autopsy be conducted in all drowning/water deaths with limited exceptions.

The panel concluded the following, which is taken verbatim from their report:

1. There was no conclusive, positive evidence for neck compression. The findings in the neck and the eyes could even have been caused by drowning or post mortem artifacts or as a result of embalming artifacts. This opinion does not exclude the possibility of neck compression, although the findings identified at the post mortem examination cannot conclusively support it.
2. Drowning can not be excluded as a cause of death.
3. There is no pathological evidence supportive of neck compression.
4. The apparent increase in thickness of the heart was likely a reflection of the state of contraction at the time of death and rigor mortis. At most, the myocardium may have been very mildly hypertrophied for the size of the individual but unlikely sufficiently so to significantly increase the risk of ventricular arrhythmia or sudden death.
5. Toxicological findings are non-contributory.
6. Agree with the cause of death as unascertained and the manner of death as undetermined.

Conclusion:

After careful consideration of all available information, including the findings of the Complex Case Expert Committee of the Ontario Forensic Pathology Service, I conclude that there remains no compelling corroborative evidence to support a cause of death finding.

I classify this death as undetermined and make no recommendations. After a full investigation and careful consideration of all available information, there is insufficient evidence to reasonably classify this death as natural, accidental, suicide or homicide.