



VERDICT AT CORONER'S INQUEST

File No.: 2007:159:0012

An Inquest was held at Port Hardy Courthouse, in the municipality of Port Hardy

In the Province of British Columbia, on the following dates November 24, 25 and 26, 2008

before Shane DeMeyer, Presiding Coroner,

into the death of Nelson Duane, 34, Male Female (Last Name, First Name) (Age)

and the following findings were made:

Date and Time of Death: September 20, 2007, 2045 hours

Place of Death: Victoria General Hospital, Victoria, British Columbia (Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Acute right subdural hematoma

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Trauma to right side of face due to a fall

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 26th day of November AD, 2008.

SHANE DEMEYER Presiding Coroner's Printed Name

Presiding Coroner's Signature





VERDICT AT CORONER'S INQUEST

**FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST
INTO THE DEATH OF**

File No.: 2007:159:0012

Nelson
SURNAME

Duane
GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Shane DeMeyer

Inquest Counsel: John Orr

Court Reporting/Recording Agency: Pat Jane, Verbatim Words West

Participants/Counsel:

Department of Justice, David Kwan
British Columbia Ambulance Service, Ian Wiebe

The Sheriff took charge of the jury and recorded 7 exhibits. 17 witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

On the evening of September 17th, 2007, the Port Hardy Royal Canadian Mounted Police (RCMP) received a report from two independent community members, and an off duty Constable, that a man, later identified as Duane Nelson, was intoxicated and "passed out" in a public place. At approximately 2113 hours, Mr. Nelson was located by RCMP and taken to cells for being drunk in a public place. He was placed in the "drunk tank" as it does not have benches or other items which could cause injury to an intoxicated individual. Mr. Nelson was provided a mattress on the floor and a blanket as the cells reportedly could be cool.

At approximately 2130 hours, RCMP members contacted the British Columbia Ambulance Service (BCAS) to attend the cells and examine Mr. Nelson as he was falling and accidentally hitting his head on the walls and floor. BCAS personnel examined and interviewed Mr. Nelson. He stated that he was "fine" and they didn't find any physical indication of further problems. The cell guards reported keeping a close watch on Mr. Nelson due to his intoxication and earlier falls.

On the morning of September 18, 2007, an RCMP member checked on Mr. Nelson at 0900 hours and attempted to wake him up. Mr. Nelson was breathing but did not wake up so he was allowed to continue sleeping. At 0947 hours the cell guard requested RCMP assistance as he was concerned about Mr. Nelson's well-being. The cell guards are not allowed to enter the cells at the Port Hardy cell block so the RCMP are required to attend.

RCMP members attended the cell and found Mr. Nelson lying on his back with his ankles crossed and an arm across his stomach with the blanket over top of him. He was described as snoring but unresponsive to pain stimulus so BCAS personnel were called to attend.



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BCAS arrived at approximately 0954 hours and did an immediate assessment. Other than a scratch by his right eye there were no obvious signs of injury. He was transported to the Port Hardy Hospital where he was taken to the trauma room. Physicians in the trauma room did a full examination and felt the lack of response to pain stimulus was potentially indicative of a brain injury. The decision was made to transfer Mr. Nelson to Victoria General Hospital where neuropathology support would be available.

Mr. Nelson arrived at Victoria General Hospital at approximately 1815 hours on September 18. A C.T. Scan was completed and showed that Mr. Nelson had a large blood clot on the right side of his brain. The decision was made not to operate as there was no meaningful chance of recovery. Palliative care measures were put in place. Mr. Nelson died on September 20, 2007 at Victoria General Hospital.



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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 Gary Bass
Royal Canadian Mounted Police, "E" Division
657 West 37th Avenue
Vancouver, British Columbia
V5Z 1K6

1. That cells designated for intoxicated individuals have padded floors and walls.

Coroner's Comments: The jury heard evidence that Mr. Nelson had struck his head on the walls and possibly the floor while falling in an intoxicated state.

2. That intoxicated prisoners placed in the "drunk tank" not be provided a blanket.

Coroner's Comments: The jury heard evidence that Mr. Nelson had requested, and been given, a blanket while in the cell. Further, the jury heard testimony that this blanket covered Mr. Nelson and hid any signs that he may have been in distress.

3. That a system be implemented to ensure that RCMP members coming on shift are aware of any "red flag" trauma incidents in cells from the previous shift.

Coroner's Comments: The jury heard evidence that RCMP members coming on shift may not be aware of problems from the previous evening.

4. That a "Head Trauma Symptom Sheet" be posted in a visible area.

Coroner's Comments: The jury heard evidence that there may be benefit for all members of the RCMP and guard staff to have an easily accessible list of symptoms consistent with head trauma.

5. That policy be developed that would direct RCMP members to initiate first aid measures when an inmate is unresponsive to pain stimulus.

Coroner's Comments: The jury heard testimony that RCMP members did not attempt first aid measures after finding Mr. Nelson unresponsive and calling for the attendance of BCAS staff.



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To: Howard Waldner
Chief Executive Officer
Victoria Island Health Authority
Victoria, British Columbia

Sue Conroy
Chief Operating Officer
British Columbia Ambulance Service
P.O. Box 9600
Victoria, British Columbia

6. That protocols be developed to facilitate the sharing of information to ensure the proper continuity of care between all agencies providing service to the patient.

Coroner's Comments: The jury heard evidence that there was not a current flow of information between different agencies due to perceived Freedom of Information issues.

To: Minister of Health
Ministry of Health Services
1515 Blanshard Street
Victoria, British Columbia

Bill Blackman
Divisional Commander
Salvation Army
#103-3833 Henning Drive
Burnaby, British Columbia

Howard Waldner
Chief Executive Officer
Victoria Island Health Authority
Victoria, British Columbia

7. To initiate plans for the development of a "sobering centre", detoxification centre, "pre" and "post" treatment safe house, and treatment facilities in Port Hardy.

Coroner's Comments: The jury heard evidence that Port Hardy experiences an extremely high level of substance misuse and that there are not any shelters, or recovery centres, for members of this population. Testimony was heard that the RCMP had become the de facto caregivers for any intoxicated persons because of this gap in service.



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To: Bev Parnham
Mayor Elect
District of Port Hardy
P.O. Box 68
Port Hardy

8. That a public awareness program be developed and delivered to highlight social issues within the District of Port Hardy.

Coroner's Comments: The jury heard evidence that the nature and degree of the substance misuse issues in Port Hardy were beyond what is generally known to the community.