BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2009:1007:0063

An Inquest was held at the Supreme Court, in the municipality of Victoria in the Province of British Columbia, on the following dates August 17th, 18th and 19th, 2010

before Shane DeMeyer, Presiding Coroner,

into the death of Vigar Kevin John 48 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)
and the following findings were made:

Date and Time of Death: June 27th, 2009 at 2115 hours

Place of Death: Victoria Police Department (Location) Victoria (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Acute Ethanol Toxicity

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:

Classification of Death: ☒ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 19th day of August AD, 2010.

SHANE DEMEYER
Presiding Coroner's Printed Name

Presiding Coroner's Signature

Vigar	Kevin John
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Shane DeMeyer

Coroner Counsel: Rodrick MacKenzie

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel:

Victoria Police Department/ Mr. David G. Butcher
British Columbia Ambulance Service/ Mr. Richard J. Meyer

The Sheriff took charge of the jury and recorded 7 exhibits. 23 witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is 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 June 27, 2009, at approximately 1922 hours, emergency services received a report of three individuals lying on the ground near the intersection of Hill Avenue and Ross Lane in Victoria, British Columbia. The individuals appeared to be unconscious with numerous empty alcoholic containers in the immediate vicinity.

Victoria Police Department personnel were the first to arrive on scene at approximately 1927 hours with the British Columbia Ambulance Service arriving moments later. At the time of their arrival, they found the two males and one female asleep on the ground. Testimony indicated that the two males roused easily while the female required assistance before rousing. All three individuals were arrested for public intoxication. At the time of the arrest, Mr. Vigar was able to walk with assistance from police personnel.

Upon arrival at the Victoria Police Station at 1939 hours, Mr. Vigar was taken to the booking room where he was assisted in removing additional clothing he had been wearing. During this process, Mr. Vigar appears to have lost consciousness and had to be supported by a Victoria Police Officer as well as a jail guard. At approximately 1957 hours, Mr. Vigar was dragged to a cell by the Officer and guard where he was placed in the recovery position due to his lack of consciousness. It was stated that Mr. Vigar was breathing and lightly snoring at this time.

The jail guard did a visual check of Mr. Vigar at 2011 hours and found him to be breathing. Another check was performed at 2021 hours and it is reported that Mr. Vigar was breathing at this time. At approximately 2040 hours, the Jail NCO did an impromptu check on Mr. Vigar and discovered he wasn't

breathing. Resuscitative efforts were started by police officers and jail staff summoned emergency health services.

Testimony indicated that Fire Department First Responders, a Primary Care unit from the BC Ambulance Service and an Advanced Life Support unit from the BC Ambulance Service arrived and took over the care of Mr. Vigar. Despite all efforts, Mr. Vigar died at approximately 2115 hours. Subsequent post mortem examination indicated that Mr. Vigar had died as a result of acute ethanol toxicity.

Vigar	Kevin John
SURNAME	GIVEN NAMES

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: Executive Team
President and Chief Executive Officer
Vancouver Island Health Authority

Chief of Police
Victoria Police Department

Minister
Ministry of Aboriginal Relations and Reconciliation

1. Recommend the creation of a joint aboriginal advisory board for addictions services including, but not limited to, the following partners: Vancouver Island Health Authority, Local First Nations Representatives, Friendship Centres, Mayor's Task Force on Homelessness, Victoria Police Department,

Coroner's Comments: The jury heard evidence that the aboriginal community has been affected disproportionately by the lack of appropriate addictions services in the Victoria area.

To: Chief Operating Officer
British Columbia Ambulance Service

2. Mandatory physical assessment (with documentation) when dispatched to a scene,

Coroner's Comments: The jury heard evidence that members of the British Columbia Ambulance Service had attended to an initial call regarding Mr. Vigar, but had not done a physical assessment of his well-being.

3. A copy of the Patient Care Report is to accompany individuals taken into custody,

Coroner's Comments: The jury heard evidence that the Patient Care Report would be of benefit to ensure that the individual received proper care at the Victoria Police cells.

Vigar	Kevin John
SURNAME	GIVEN NAMES

To: Minister
Ministry of Public Safety and the Solicitor General

4. Recommend visible posting of sections of the Liquor Control and Licensing Act pertaining to not selling/serving alcohol to impaired individuals at all licensed retail locations and provincial liquor stores,

Coroner's Comments: The jury heard evidence that Mr. Vigar had been served at a local provincial liquor store on three occasions on the day of his death.

To: Executive Team
President and Chief Executive Officer
Vancouver Island Health Authority

5. Recommend additional beds for supportive housing, detox, and sobering as well as aboriginal specific beds,

Coroner's Comments: The jury heard evidence that Victoria does not have enough beds to assist aboriginal and non-aboriginal people who have addictions problems,

6. Recommend cultural awareness training for Vancouver Island Health Authority staff,

Coroner's Comments: The jury heard evidence that many aboriginal people do not access Vancouver Island Health Authority resources due to a lack of cultural appropriateness,

To: Chief of Police
Victoria Police Department

7. Recommend visible posting of jail policies governing the medical care of persons in custody including rousability and questionable consciousness,

Coroner's Comments: The jury heard evidence that police officers and jail guards were not aware of current policies regarding the medical care of people for whom they were responsible.

8. Ensure all Jail NCO's have Level 3 First Aid certification,

Coroner's Comments: The jury heard evidence that there is a lack of adequate first aid training for staff working within the cell area.

9. When appropriate, provide verbal policy change briefings in addition to current practice of e-mailing policy changes,

Coroner's Comments: The jury heard evidence that policy changes were often not reviewed adequately as they were sent out through e-mail.

10. Review and update the Prisoner Medical Information Sheet to ensure it conforms with the direction of the Victoria Police Department Jail Policy and Procedure Manual,

Coroner's Comments: The jury heard evidence that the current Prisoner Medical Information Sheet does not include information that would be relevant to fulfilling the goals of the Victoria Police Department Jail Policy and Procedure Manual.

11. Ensure that all first aid training for Victoria Police staff is current, and establish mandatory recertification within the training plan,

Coroner's Comments: The jury heard evidence that Victoria Police staff were not consistently up to date on basic first aid procedures.

12. Victoria Police Department jail guards should have training equivalent to that of the Vancouver Police Department jail guards.

Coroner's Comments: The jury heard evidence that the training provided to the Vancouver Police Department guards is superior to that provided to the Victoria Police Department guards.