DECISION OF THE

GENERAL MANAGER

LIQUOR CONTROL AND LICENSING BRANCH

IN THE MATTER OF

A hearing pursuant to Section 20 of

The *Liquor Control and Licensing Act,* R.S.B.C. 1996, c. 267

Licensee:	GMJ Pub and Liquor Corporation dba Gorge Pointe Pub 1075 Tillicum Road Esquimalt, BC V9A 2A4
Case:	EH12-043
For the Licensee:	James A.S. Legh
For the Branch:	Olubode Fagbamiye & Cristal Scheer
General Manager's Delegate:	Nerys Poole
Date of Hearing:	May 13, 14 and 15, 2013
Place of Hearing:	Victoria, BC
Date of Decision:	September 13, 2013

INTRODUCTION

The licensee, GMJ Pub and Liquor Corporation (the "Licensee") operates the Gorge Pointe Pub (the "Pub") located in Victoria, BC. The Pub operates under Liquor Primary Licence #158089 (the "Licence") with liquor sales from 11:00 a.m. to 1:00 a.m. Monday to Saturday and to midnight on Sunday. R. Thomas Burley is a director of the corporate Licensee and appeared as the Licensee's representative during the course of the hearing. The Licence is, as are all liquor licences issued in the province, subject to the terms and conditions contained in the publication "Guide for Liquor Licensees in British Columbia" (the "Guide").

The events of August 27, 2011 led to the tragic death of a 54 year old woman. The issue for me, as delegate of the General Manager, is to listen to the evidence presented and to determine whether the over-service at the Pub warrants a 30 day suspension and if not, what penalty is reasonable and appropriate in the circumstances of this incident.

Brief Narrative of Events of August 27, 2011

On Saturday, August 27, 2011, at about 2:40 p.m., four patrons entered the Pub. They were in the Pub for about four hours. One couple was visiting from out of town while the other couple resided in Victoria. Prior to coming to the Pub, the two males, identified in this decision as Male Patron A and Male Patron C, drank a beer each at the residence of the Victoria couple. Female Patron B had one beer and a coffee at the residence while Female Patron D had no alcoholic drinks before going to the Pub.

The four patrons sat at table 36 in the Pub and were served by three different servers over the course of their time in the Pub. At roughly 6:25 p.m., Female Patron D started showing obvious signs of impairment.

The patrons paid their bill at around 6:45 p.m. and left the Pub in a taxi at 6:54 p.m. Male Patron A carried Female Patron D from the Pub as she was unable to walk on her own. The other three patrons displayed no signs of impairment during the time in the Pub and left the Pub without showing any signs of intoxication.

At the residence of the Victoria couple, Male Patron A carried Female Patron D to the apartment, where she was laid face down on her bed at about 7:30 p.m. She consumed nothing further at her home. Her husband, Male Patron C, awoke at 2:00 a.m. and found her unresponsive beside him. He or Female Patron B called 911. He began resuscitation and the first responders arrived and continued resuscitation until it was clear that she had died several hours before the paramedics arrived, roughly around 10:00 p.m. The coroner listed the cause of death as "lethal ethyl alcohol toxicity."

The Liquor Control and Licensing Branch (the "branch") became aware of the incident as a result of receiving a report from the police on August 28, 2011. The police proceeded with their investigation which included interviews with the three patrons who were in the company of the deceased woman, two of the Pub's servers, and a paramedic. The police provided transcripts of these interviews to the branch on July 30, 2012.

ALLEGED CONTRAVENTION AND PROPOSED PENALTY

The branch's allegations and proposed penalty are set out in the Notice of Enforcement Action dated June 11, 2012 (the "NOEA"), found at Exhibit 1, tab 1.

The branch alleges that on August 27, 2011, the Licensee contravened section 43(2)(a) of the *Liquor Control and Licensing Act* (the "*Act*") by permitting a person to become intoxicated. The proposed enforcement action outlined in the NOEA is a 30 day suspension. This proposed suspension falls outside the penalty range set out in item 10, Schedule 4 of the *Liquor Control and Licensing Regulation* (the "*Regulation*") for a first contravention of this type. Item 10 provides a penalty range of a four to seven days

licence suspension and/or a monetary penalty of $5,000-$7,000 for a first contravention of this type.

In the alternative, if I do not find that the Licensee contravened section 43(2)(a) of the *Act*, the branch alleges that on August 27, 2011, the Licensee contravened section 43(2)(b) of the *Act* by permitting an intoxicated person to remain. The proposed enforcement action for this alternative contravention is a 30 day suspension. This proposed suspension falls outside the penalty range set out in item 11, Schedule 4 of the *Regulation* for a first contravention of this type. Item 11 provides a penalty range of a four to seven day licence suspension and/or a monetary penalty of $5,000-$7,000 for a first contravention of this type.

The Licensee admits the contravention of section 43(2)(a) occurred and does not raise a defence of due diligence. The Licensee disputes the proposed penalty and says it is excessive and unfair.

RELEVANT STATUTORY PROVISIONS

Liquor Control and Licensing Act, R.S.B.C. 1996, c. 267

Drunkenness

43 (1) A person must not sell or give liquor to an intoxicated person or a person apparently under the influence of liquor.

(2) A licensee or the licensee's employee must not permit

(a) a person to become intoxicated, or

(b) an intoxicated person to remain in that part of a licensed establishment where liquor is sold, served or otherwise supplied.

Action against a licensee

20 (2.1) The general manager may, if he or she is satisfied that it is in the public interest to do so,

(a) impose a monetary penalty under subsection (2) (c) that is greater than the amount provided for in the prescribed schedule of penalties, or

(b) suspend a licensee's licence under subsection (2) (d) for a period longer than that provided for in the prescribed schedule of suspensions.

(2.2) The general manager must, in taking action against a licensee under subsection (2.1), take into account

(a) the licensee's entire compliance history in respect of the matters referred to in subsection (1), and

(b) the particular circumstances giving rise to the taking of action by the general manager.

ISSUES

1. Did the contravention occur?
2. If so, has the Licensee established a defence to the contravention?
3. If the contravention is proven, what penalty, if any, is appropriate?

EXHIBITS

Exhibit 1: Branch Book of Documents, volumes 1 and 2, tabs 1 to 26

Exhibit 2: Closed Circuit TV video surveillance tape from the Pub

Exhibit 3: Original Receipts of bill paid by one of the patrons

Exhibit 4: One page of police sergeant's (Police Officer E) handwritten notes

Exhibit 5: Resume of the Physician

Exhibit 6: Licensee's Book of Documents, tabs 1 to 11

Exhibit 7: Email dated September 20, 2012 between Liquor Inspector and James Legh, Licensee's legal counsel

EVIDENCE – THE BRANCH

The branch called eight witnesses, including one toxicology consultant, and submitted transcript evidence of interviews with others involved in the incident. The branch's evidence is summarized as follows.

Police Officer A

Police Officer A is a constable with the Victoria Police Department (VPD) and has worked as a police officer since 1999.

Police Officer A testified that, on the night of August 27/28, 2011, she was on duty on the night shift. Responding to a 911 call, she attended at a residence in Victoria. She was advised that, shortly before 02:00 hours on August 28, 2011, a male had called requesting an ambulance. He said that he had woken up next to his wife whose lips were blue and that she was cold to the touch. Police Officer A and her partner arrived at the residence at 02:15 hours. At the time of their arrival, the Provincial Ambulance Services crew was packing up their equipment and had stopped revival efforts of the woman. The constable met the deceased woman's husband who was very distraught.

Police Officer A and her partner then searched all the rooms in the apartment, including: the deck, all closets, drawers, cabinets, garbage cans, medicine cabinets, and the woman's purse. They were looking for any drugs or prescription medicines that might help the coroner determine the cause of death. Police Officer A testified that they found no prescription medicines or drugs in the apartment. They found an empty case of Kokanee beer and four empty beer cans, including one in the living room and another on the balcony.

Police Officer A spoke briefly with the deceased woman's husband (Male Patron C). She spoke with two others, a male and a female (Male Patron A and Female Patron B), who were staying overnight in the apartment as guests of the husband and the deceased woman (Female Patron D). The husband said his wife had been in excellent health. Police Officer A testified that the husband had an odour of liquor on his breath, as did the visiting couple in the apartment.

Police Officer A said she spoke more to Female Patron B than to Male Patron A. They both stated they had all been drinking earlier in the evening. Female Patron B advised the constable that she and her boyfriend were both visiting Victoria and that she knew the husband (Male Patron C), who had suggested they come to his home when they arrived in Victoria. They met his wife for the first time that afternoon when they went to their apartment.

According to Police Officer A, Female Patron B stated that at about 15:00 hours they all walked to the Pub which was a short distance from the apartment. According to Female Patron B, they proceeded to drink heavily. Police Officer A inquired whether they had eaten. Female Patron B stated that they had consumed only a plate of nachos. Shortly after receiving the bill, someone called a taxi and they all returned to the residence of the Victoria couple.

Female Patron B told Police Officer A that, while in the taxi, Female Patron D stated that she felt sick and vomited some clear fluid into a napkin. When the taxi arrived at the residence, Female Patron D was unable to walk, so Male Patron A carried her into the apartment building to the elevator and then to the suite. He then placed her face down on the bed in her bedroom, at approximately 19:30 hours.

During Police Officer A's attendance in the apartment, she stood by the door and monitored the ambulance crew who were in attendance. She testified that the ambulance crew left about 02:39. Shortly after 03:00, a male appeared at the home. He was a long time family friend of the deceased woman and her husband and a retired Saanich police officer. He said he had known the deceased woman for years and had only seen her drink alcohol about three times and, each of those times, she was extremely intoxicated. The coroner arrived at 02:48 and advised that the time of death was approximately 22:00 hours. Police Officer A left the residence some time after 4:00 or 5:00 a.m.

Police Officer A testified that she prepared a report for the coroner, outlining her observations of the night. She had brought in her mobile data recorder and prepared the report that night. She identified her report at Exhibit 1, tab 8.

When asked about the concerns of the police with respect to permitting a person to become intoxicated, Police Officer A responded that the police are sworn to protect life and property and that intoxicated people can become a danger to themselves and to others.

On cross-examination, Police Officer A agreed that the Pub is a good pub, that she has visited the Pub on social occasions (when off duty), and that it is not generally a problem establishment. She stated that the fact that she goes there when off duty indicates that. She could not recall any other incidents related to liquor contraventions at the Pub that required police attendance in the last three years.

Police Officer B

Police Officer B has been with the Victoria Police Department for 23 years and is currently a staff sergeant. He was lead investigator on this incident. The purpose of his investigation was to determine if there was any criminality with respect to the death of Female Patron D.

Police Officer B testified that he conducted interviews with Male Patron A and the paramedic who attended the residence. He interviewed Male Patron A on October 28, 2011. He estimated Male Patron A's memory of that day and evening to be about 50%. A summary of that interview from the transcript is set out below under Transcript Evidence.

Police Officer B conducted an interview on October 28, 2011 with the paramedic who attended the residence in the early morning hours of August 28, 2011. A summary of that interview from the transcript is set out below under Transcript Evidence.

Police Officer B testified that he received a copy of the video surveillance from the Closed Circuit TV (the "CCTV") in the Pub and other documents from the branch. He reviewed the CCTV video footage himself. When he discovered that Male Patron C had left Victoria, he arranged for a police officer to interview Male Patron C in the city where he was now living. He prepared the questions for that interview (Transcript Evidence below). He also spoke with the coroner.

He stated that the concern of the police department with over-service is public safety, that is, the welfare of individuals themselves as well as the welfare of other patrons and the need to keep the peace.

On cross-examination, Police Officer B agreed that the Pub was not the kind of place that draws a lot of attention from the police. He has attended there on social occasions himself.

Police Officer C

Police Officer C has been a constable with the Victoria Police Department for about 9½ years. Prior to that, he was a member of the Saanich Police Department for about eight years. On August 27, 2011, he was a detective with the major crimes unit. He became involved with this file when he was asked to interview one of the servers in the Pub (Server 3).

He conducted an interview with Server 3 at his office on February 14, 2012 (summary included under Transcript Evidence below). Server 3 testified at this hearing.

Police Officer C testified that he remembered the interview well because of Server 3's young age and her emotional state. At one point, she was in tears. It was clear to him that she was genuinely upset that someone had died as a result of consumption at the Pub and that she was not trying to hide anything.

When asked about the concerns of police with respect to intoxication, Police Officer C stated that they are concerned about individuals' well-being as well as the public in general as, when people become intoxicated, they may become more belligerent.

On cross-examination, Police Officer C said he has visited the Pub only once, on a social occasion. He agreed it was a fairly low key establishment, not a problem type facility, and in his experience did not attract police attention.

Police Officer D

Police Officer D has been a detective with the Victoria Police Department for three years. On August 27, 2011, she was a detective with the major crimes unit.

On October 28, 2011, Police Officer D conducted the interview with Female Patron B and prepared a summary of her interview on November 1, 2011 (Exhibit 1, tab 15(b)). A summary of the transcript of this interview is set out below. She kept the original two bar tab receipts given to her by Female Patron B, marked as Exhibit 3 in this hearing.

With respect to police concerns about intoxication, Police Officer D stated that the two primary concerns are the impact on public safety and the potential danger that intoxicated individuals may pose to themselves.

On cross-examination, she agreed that in her three years with the major crimes unit, this was the only time she was aware of anything negative with respect to the Pub.

Police Officer E

Police Officer E has been a sergeant with the Victoria Police Department for 28 years. He was not initially involved with the incident on August 27, 2011. He was transferred in January of 2012 to the major crimes unit and took over the file from Police Officer B in February of 2012.

His task was to sum up the file and attempt to interview the final witnesses. Police Officer E testified that he interviewed Server 1 on March 22, 2012. He created a summary of this interview and typed this up immediately after the interview, using the video and the audio tape of the interview to ensure its accuracy. He reviewed the file, viewed the CCTV video, created a timeline, and created a disclosure package for the branch liquor inspector. His one page of handwritten notes of his observations of the videotape was entered as Exhibit 4.

Police Officer E stated that police concerns with respect to intoxicated persons are primarily safety issues in that individuals may become a danger to themselves or to others.

On cross-examination, he stated that he has attended the Pub, once with his soccer team, and a few times with regards to this file. Police Officer E agreed that the Pub has a reputation of being a fairly well run establishment, and that there are no problems from a policing perspective. He was an old family friend of Server 3 so did not interview her. Police Officer E agreed that he never advised Server 3 that this was not an appropriate place to work.

Police Officer E agreed that, in viewing the video, he observed a very short period of time in which Female Patron D went from appearing normal to appearing very intoxicated.

In redirect, Police Officer E agreed that his notes indicate that at 18:43 Female Patron D was "in and out of consciousness". He further agreed that someone watching the video can make his/her own assumptions.

Toxicology Consultant

The branch asked to qualify the Toxicology Consultant as an expert in the absorption, elimination and distribution of alcohol in the human body. The Licensee had no objection. I reviewed the Toxicology Consultant's curriculum vitae at tab 23 of Exhibit 1 and qualified him as an expert in this field. The Toxicology Consultant submitted an expert report dated March 11, 2013 (Exhibit 1, tab 23).

The Toxicology Consultant testified that he is a consultant in the area of forensic alcohol and drugs. He worked for 34 years for the RCMP, retired in 2004 and now acts as a private consultant in this area. He has published and continues to give scientific papers on the effects of alcohol and drugs in the human body. He has given expert testimony in provincial and superior courts in B.C., the Yukon Territory, Alberta, Saskatchewan and Prince Edward Island, and has been involved in hundreds of cases over his career.

The Toxicology Consultant formed the basis for his conclusions in his report from documents provided by the branch. These included the coroner's report, the toxicology analysis, and information on the drinking pattern of the deceased. The Toxicology Consultant had not watched the video prior to writing his opinion. He watched it on the morning of the hearing prior to testifying.

<u>Expert report</u>

According to his expert report, the Toxicology Consultant relied upon the following assumptions:

- information about the blood alcohol concentration ("BAC") of Female Patron D at the time of her death
- an estimate of the amount consumed in the Pub
- that the alcohol was consumed equally by all four patrons
- that Female Patron D weighed 130 lbs

In his report the Toxicology Consultant concluded that, at the time she left the Pub, Female Patron D's BAC would have been 330 to 360 mg%, based on an average elimination rate of between 10 and 20 mg% per hour of alcohol from the body. He stated that this is valid only if all the alcohol consumed were absorbed into the blood.

In order to have a BAC of 330 to 360 mg% at the time of leaving the Pub, the Toxicology Consultant opined that Female Patron D, at an assumed weight of 130 lbs., would have consumed the equivalent of approximately 8.6 to 9.4 bottles or cans of beer or 12.9 to 14 ounces of 40% alcohol (hard liquor) absorbed in the blood at the time she left the Pub.

Based on the drinking pattern as provided to him by the branch, Female Patron D would have consumed 1.25 jugs of beer, 1.5 glasses of wine, and six shooters between 14:40 hours and 18:54 hours. If all of this alcohol was completely absorbed into the blood at 18:54 hours, the Toxicology Consultant concluded her BAC would have been between 329 to 371 mg%, again assuming a weight of 130 lbs.

The Toxicology Consultant further stated in his report that it takes 30 minutes to one hour for a drink of alcohol to be absorbed and the peak blood alcohol concentration to be reached. Such factors as the amount and type of food in the stomach, the concentration of the beverage, the rate of consumption of the beverage, diseases and emotional states, and drugs may slow the absorption of alcohol from the stomach and the small intestine.

His report outlined the Dubowski's "Seven Stages of Alcohol Influence" which include (only last four stages listed here):

BAC	**Stage of Alcohol Influence**	**Clinical Signs/Symptoms**
180-300mg%	Confusion (4^{th} stage)	• Disorientation, mental confusion, dizziness • Exaggerated emotional states (fear, anger, grief etc.) • Disturbances of sensation (diplopia) and of perception of color form, motion, dimensions • Decreased pain sense • Impaired balance, muscular in coordination, staggering gait, slurred speech
270-400 mg%	Stupor (5^{th} stage)	• Apathy, general inertia, approaching paralysis • Marked decreased response to stimuli • Marked muscular incoordination, inability to stand or walk • Vomiting, incontinence of urine and feces • Impaired consciousness or sleep or stupor
350-500 mg%	Coma (6^{th} stage)	• Complete unconsciousness, coma, anaesthesia • Depressed or abolished reflexes • Subnormal temperatures • Incontinence of urine and feces • Decreased circulation and respiration • Possible death
450 mg%	Death (7^{th} stage)	• Death from respiratory paralysis

Under the Opinion section in his report, the Toxicology Consultant concluded that:

1. Female Patron D, at a BAC of between 330-360mg% at the time of leaving the Pub, was either in the 4th or 5th stage of intoxication (confusion or stupor) and would be exhibiting some or all of the signs and symptoms listed in the table above.
2. From the signs and symptoms described of Female Patron D she was obviously intoxicated and was either in the 4th or 5th stage of intoxication or possibly higher while inside the establishment on the night in question.
3. Female Patron D, if classified as a novice to social drinker, at a BAC of between 330-360 mg% would be showing obvious signs of intoxication that would be visible to the general public.
4. Female Patron D would have the equivalent of approximately 8.6 to 9.4 bottles or cans of beer or 12.9 to 14 ounces of 40% alcohol absorbed in her blood at the time she left the Pub.
5. Female Patron D's drinking pattern on the night in question, if she weighed 130 lbs, also matches her BAC range at the time of leaving the Pub.
6. It takes approximately 20 to 30 minutes on an empty stomach for the alcohol to be absorbed and for the subject to reach her maximum BAC.
7. Vomiting usually occurs when a large volume of alcohol is absorbed over a short time.
8. Female Patron D, from the start of drinking to finish of drinking, would have shown a progression of symptoms of intoxication as her BAC increased from a low BAC to a higher BAC. Female Patron D would have shown signs of intoxication far before she passed out and had to be carried out of the Pub.
9. In conclusion, the Toxicology Consultant opined that Female Patron D should not have been served any more alcohol far earlier in the evening while in the establishment.

Oral testimony of the Toxicology Consultant

The branch advocate led the Toxicology Consultant through his report. The Toxicology Consultant emphasized that the coroner's report, the toxicology analysis, and the drinking pattern of the deceased formed the basis of his expert testimony.

He stated that 300 mg% is an extremely high blood alcohol level. The Toxicology Consultant testified that his calculation of the BAC does not change as long as the amount of alcohol consumed is the same. A specific amount of alcohol will get into the blood and then take over the elimination pattern. If Female Patron D's drinking pattern varied a bit, more wine and less beer, that doesn't change his opinion as to how much alcohol was in her system.

When asked how a person with a BAC at this level would react, the Toxicology Consultant stated that a novice drinker would be barely able to stand or walk. He/she could be passed out at this level. There would be gross signs of intoxication. He/she would not be able to carry on a proper conversation, vision would be impaired, reaction time would be very slow, and judgement would be impaired.

When asked specifically about the service to Female Patron D, the Toxicology Consultant testified that, with the amount of drinks she had been served, there would have been obvious signs of intoxication, especially in a person who is a novice drinker. These signs and symptoms should have been obvious much earlier and she should have been cut off at a much earlier stage.

Cross-examination

In cross-examination, the Toxicology Consultant agreed that a person could have a BAC, as indicated on his chart of the levels of intoxication, but still not show the signs indicated in the chart. He agreed that these are average signs and symptoms and agreed that someone with a BAC of 430 mg% or 420 mg% could be driving a car. He stated he had seen a BAC of 510% and the person was still functioning and not dead.

He agreed that some people with a high BAC, particularly an experienced drinker, may have learned to hide or mask the signs of intoxication. It depends on an individual's metabolic tolerance, physical tolerance, and learned tolerance.

The Licensee's counsel referred to evidence that Female Patron D went from "0 to 60" very quickly, from appearing fairly normal to exhibiting severe signs of intoxication. The Toxicology Consultant agreed that some people pass through the various stages very quickly and that the BAC can rise very quickly. He stated, however, that to get to a BAC of 330 to 360 mg%, a large amount of alcohol was consumed. The Toxicology Consultant could not see this amount of alcohol being consumed without showing signs of intoxication during the period of consumption.

The Toxicology Consultant agreed that a person can go from no alcohol to dead in 20 minutes, depending on how fast the individual may have drunk the alcohol. For example, someone who chugs back a 26 ounce bottle of alcohol within that time frame will most likely die.

When asked about evidence suggesting Female Patron D drank only 5 glasses of wine and 4 shooters, the Toxicology Consultant stated that she would not have reached the BAC of 330-360 mg% with that amount of alcohol consumption.

He agreed he had no personal knowledge of what Female Patron D drank, only what he had outlined in his report. The Toxicology Consultant was asked to calculate the BAC if she only drank 6 glasses of wine (5 ounces each) and 4 shooters over four hours. He calculated that, with this drinking pattern, the BAC would have been 250 to 290 mg**%.** The Toxicology Consultant agreed that if the shooters were drunk rapidly at the end of the drinking session the BAC would rise rapidly, and that he was aware of this as an expert in this field.

He was asked if it was common knowledge to a layperson that a person who drinks a number of shooters in a brief period of time would become intoxicated very quickly. The Toxicology Consultant said he believed that most people are aware that when one drinks more quickly one becomes drunker faster.

Licensee's counsel asked how Female Patron B was able to drink possibly more, but certainly an equivalent amount of alcohol, and she was still able to leave the Pub, apparently not exhibiting signs of intoxication. The Toxicology Consultant noted that it is a matter of individual tolerance. The body of an individual of a similar size who is used to drinking more alcohol will deal with it more quickly. This person will not show the same overt signs of intoxication as an intolerant person will.

When asked how the plate of nachos may have affected Female Patron D and her BAC, the Toxicology Consultant said it has no direct effect on the eventual BAC. He said, if one eats before drinking, this will slow down the absorption of the alcohol in your blood. He acknowledged that if she ate a plate of nachos before drinking the shooters, this may have slightly slowed down the absorption of alcohol into her blood level.

When asked about the average rate of 95% of the population to eliminate alcohol at 10 to 20 mg per hour, the Toxicology Consultant stated that if a person is healthy this is likely the level of elimination from their blood. If a person is an intolerant drinker, usually the signs of intoxication will occur more quickly. He did not believe that an intolerant drinker would not show any signs and then suddenly show signs of intoxication. When questioned about male/female tolerance levels, he agreed that if a man and woman of the same weight consume the same amount of alcohol, the woman will have a BAC 1.2 times higher than the man.

The Toxicology Consultant agreed that all the important facts and assumptions leading to his opinion are set out in his report and that if the assumptions change, his opinion would change

Police Officer F

Police Officer F gave testimony via teleconference as he is a sergeant with a police department in a city in Alberta, where Male Patron C (husband of the deceased) currently lives. He has been employed with the police department there for 16 years. He received a request from a sergeant with the Victoria Police Department (Police Officer B) to interview Male Patron C. He interviewed him on November 21, 2011. He recorded the interview both by audio and video and then had it transcribed (Exhibit 1, tab 15(d)). He did not compare the transcript to the tape. He reviewed the transcript in preparation for his testimony at the hearing. A summary of this transcript is set out below. After this interview, Police Officer F had no further involvement with this file. He sent off all the material to Police Officer B as requested.

When asked about police concerns with intoxication, he stated they deal with this issue all the time. Their concerns revolve around public safety, including impaired driving, people making poor decisions and being a danger to themselves.

Liquor Inspector

The Liquor Inspector has worked for the branch for 8 years. She was responsible for issuing the Contravention Notice on September 20, 2011 (Exhibit 1, tab 2), and subsequently the NOEA on June 11, 2012 (Exhibit 1, tab 1). The Liquor Inspector did not work on the evening of August 27, 2011, nor did she attend the Pub on that day or evening.

The Liquor Inspector has spent the last two years covering the Victoria, Esquimalt, Sooke and Port Renfrew region. Her duties include responsibility for inspections of the Pub. She has received training about intoxication through the Justice Institute and through internal training with the branch.

She has performed over 500 inspections in her career as a liquor inspector. The key things she looks for when inspecting a licensed establishment are service to minors, overcrowding, over-service, community disturbance issues and general staff conduct.

When she visits a licensed establishment to determine if there has been any over-service, she looks for signs of intoxication which include physical signs, such as staggering, droopy head or eyes. She will try to engage with a patron to determine if she/he has slurred speech and/or an odour of liquor.

The Liquor Inspector reviewed the terms and conditions of the Pub's liquor primary licence (Exhibit 1, tab 3), which include the terms and conditions set out in the Guide (Exhibit 1, tab 6). She stated the purpose of the Guide is to set out, in plain language, the Act and Regulations and some of the branch policies to guide a licensee on how to sell and serve inside its establishment.

She reviewed the information in the Guide with respect to over-service, the physical signs of intoxication to watch out for, the role of a licensee, the importance of Serving It Right certificates, and the requirement for licensees to maintain photocopies of these certificates for all their employees.

The Liquor Inspector reviewed the Serving It Right manual (Exhibit 1, tab 7) and its importance as a tool for licensees and persons working in the industry, to make them aware of their responsibilities and the issues that occur when serving liquor. She referred specifically to the importance of written policies and how such policies can provide procedures and practical tactics appropriate for use in different alcohol-service situations (page 40 of tab 7). She noted the sample policies for licensees to incorporate in the management of their business, in particular a sample policy for refusing service to intoxicated patrons. The Liquor Inspector testified that she did not receive any written policies on intoxication from the Licensee.

She noted that Appendix G in the Serving It Right manual provides a sample of an incident report. When asked if the Licensee submitted an incident log, the Liquor Inspector said that the Licensee provided a document (tab 20 of Exhibit 1) that has the heading of incident report, but that it is not an incident report. The document at tab 20 is headed "Incident Report. Gorge Pointe Pub" and has a list of staff names, their

addresses and Serving It Right certificate numbers, and nothing else. She noted that the date of the Serving It Right certificate for Server 3 is August 31, 2011, four days after the incident on August 27, 2011. The Licensee's counsel acknowledged that this server obtained her Serving It Right certificate after the date of the contravention.

The Liquor Inspector identified tab 5 of Exhibit 1 as the Inspection Interview Sheet that was filled out at the time of the transfer of ownership of the Pub. She noted that, amongst other things, the Licensee acknowledged that the over-service and intoxicated persons section of the Guide was discussed.

The Liquor Inspector testified that she received an email from a police officer, who was working on the night of August 27/28, 2011, informing her that there had been a death and that the deceased had been served in the Pub several hours before. On August 29, 2011, the Monday morning after the incident, the Liquor Inspector started to collect reports from the Victoria Police Department and the Coroner's Office. She then contacted the Licensee.

The police provided her with the transcripts and the audio recordings of the interviews they conducted as part of their investigation. The Liquor Inspector listened to the audio recordings of all those interviewed by the police. She drew conclusions about the events from these audio recordings. The four patrons had attended the Pub for drinks and had been there over a period of four hours. This was a social get together and all four were drinking heavily. The Liquor Inspector concluded that over-service occurred. She further concluded, from listening to the audiotape of the interviews, that the memories of all three were skewed. They all believed that they walked out of the Pub together. After listening to the interviews, it was apparent to the Liquor Inspector that, once presented with the fact that Female Patron D was unable to walk on her own, the three started to question their own judgement and memory.

The Liquor Inspector testified that she sent the Licensee four Notices to Provide Records (Exhibit 1, tab 9), each time narrowing down the request for documents. She obtained the CCTV video surveillance tape as a result of the August 29, 2011 Notice. The Liquor Inspector watched the video and made some specific observations from this. The Liquor Inspector observed some strong signs of intoxication. She observed staff attending at the table and noted that in the last hour there were approximately 11 staff interactions at that specific table. She counted every time a staff member walked by the table and concluded a staff member would have walked by 127 times.

She reviewed the Checks Reports from the Pub (Exhibit 1, tabs 10 and 11). From these, the Liquor Inspector was able to identify table 36 as the table where the subject patrons were seated. She reviewed the number of drinks provided to that table and the number of drinks ordered or charged to that table. The Liquor Inspector identified the following:

- The first bill issued to table 36 was for $69.42, with a time frame of 2:44 p.m. to 4:21 p.m. noted on the report
- The second bill was for $99.14, with a time frame of 4:30 p.m. to 7:05 p.m.
- The third bill was for $102.00, with a time frame of 4:30 pm to 7:05 p.m.
- The total amount charged to table 36 was $270.56, excluding the tip that was added to the second bill (visa receipt of $111.96)

The Liquor Inspector identified the photos at Exhibit 1, tab 13, 1 to 9 as photos taken from the video surveillance tape, and number 10 to 12 as photos from Female Patron B's camera. The Liquor Inspector identified Exhibit 1 tab 17(ii) as her working notes breaking down the receipts that showed combined bills with a total of $283.38 (discrepancy here is the tip added to the 99.14 bill to make it a total of 111.96 on the visa receipt). Tab 18(a) is the chronological statement the Liquor Inspector provided to the Victoria Police Department about her actions during the early part of the investigation. Tab 18(b) is a statement from another liquor inspector who had some involvement in this file.

When asked about her efforts to interview the three patrons at table 36, the Liquor Inspector stated she had contacted Police Officer E at the Victoria Police Department who sent her the addresses that he had on file. The branch then sent out letters to the individuals at those addresses and the letters were returned to the branch office. The branch used investigators in Vancouver to try to locate these patrons, but without success. She was unfamiliar with exactly what was done to try to locate them.

The Liquor Inspector acknowledged that, under Schedule 4 of the *Regulation*, the recommended suspension for a first contravention of this type is four to seven days, or a monetary penalty of $5000 to $7000. She stated that she determined enforcement action was necessary in this case because of the egregious over-service that occurred in the Pub on August 27, 2011.

She explained her reasons for recommending a thirty (30) day suspension as the penalty. The Liquor Inspector stated that this was one of the hardest recommendations she has made in her career as a liquor inspector and that she struggled a great deal with it. She has never had a file like this one before. The Liquor Inspector did not know how to put a number on such a situation. She looked at the minimum of four days and the maximum of seven days, and the circumstances, and all the information that she had surrounding the events of August 27, 2011. The Liquor Inspector noted that a woman entered the Pub in a sober state and became so intoxicated she had to be carried out of the Pub. She looked at the responsibility of the Licensee here and the staff involvement. She concluded that the staff could have stepped in earlier. She decided to recommend a severe penalty to send a strong message to the Licensee, its staff and the community.

The Liquor Inspector noted that intoxicated persons may lose their ability to make sound judgements and proper decisions. They may become a risk to themselves, to staff and to other patrons. In this case, Female Patron D became a risk to herself.

Cross-examination

Under cross-examination, the Liquor Inspector agreed that she set out her reasons for recommending a thirty day suspension in the NOEA. The NOEA refers to service to table 36 of “5 jugs of beer, 6 glasses of wine and 25 shooters.”

Licensee’s counsel asked if her estimate of what was served to this table, as set out in the NOEA, was actually less than suggested and if so, how would this affect the penalty. The Liquor Inspector responded it would not affect her recommendation, as the intoxication level of Female Patron D remains the same and, therefore, her opinion would not change. She agreed that the recommendation of thirty days was based on the gross over-service of liquor, as referred to in the NOEA. She also stated that she was of the view that the server continued to serve liquor to the table after it was apparent that Female Patron D was intoxicated.

The Liquor Inspector acknowledged she had no personal knowledge of this and that she based some of her comments in the NOEA on the coroner’s report which states “can be seen on the recording as increasingly intoxicated and later lapsing into periods of unconsciousness” (Exhibit 1, tab 21, page 3). She agreed the coroner was not present at the Pub. The coroner also stated at page 3 of his report that “additional alcohol drinks continued to be served to the table while [Female Patron D] displayed these increasing signs of intoxication.”

The Liquor Inspector stated that, in observing the video, she saw signs of intoxication and then what she thought was more liquor being served to the table. At 18:18 she saw a server at the table with a serving tray. The Liquor Inspector admitted that she made an assumption from this video footage that the service of liquor was continuing, and that she did not actually see the service**.** The Liquor Inspector admitted that, when the table was cleared, she did not actually know what was cleared off at that point. She merely observed the server coming to the table. She agreed she made no mention of failure to clear the table of any liquor in the NOEA.

Under reasons for pursuing enforcement, at page 5 of the NOEA (Exhibit 1, tab 1), the Liquor Inspector referred to Female Patron D "having to be carried out of the pub and sent home in a taxi." She adds in the NOEA: "An ambulance would have been better suited to her medical condition at the time." The Liquor Inspector agreed that this was another reason for suggesting a 30 day suspension**.**

Another reason for recommending 30 days is explained in the NOEA (page 7): "The circumstances of gross over-service combined with what appears to be a collective and willful disregard for its primary responsibility, the safety of its patrons, the licensee failed to abide by its legal obligations and contrary to any rudimentary common sense continued to serve liquor beyond the amount any reasonable person might consider rational."

The Liquor Inspector was not aware of how much liquor was actually on the table. When asked what was done to justify the use of "wilful disregard" in the NOEA, she stated that a server should recognize that people metabolize differently and that the server should be aware of the signs of intoxication, regardless of the specific amount being consumed.

She agreed that there were three others at the table with no overt signs of intoxication. The Liquor Inspector agreed that staff should watch people because they exhibit different levels of intoxication based on different amounts of liquor.

When asked if she considered the fact that Female Patron D went from no symptoms of intoxication to a number of serious signs of intoxication in a very short period of time, the Liquor Inspector replied that the staff had the advantage of hearing her talk and watching her mannerisms there. She just watched the video.

The Liquor Inspector stated that she could not have access to the staff, as the Licensee's counsel indicated in an email that she could not interview them. The email dated September 20, 2011 was entered as Exhibit 7. She agreed that she did not respond when the Licensee's counsel asked her for a list of specific questions.

The Liquor Inspector stated that if staff had not continued to serve liquor "beyond the amount any person considered rational", this would not affect her recommendation of thirty days. She agreed that, ultimately, her recommendation was because Female Patron D passed away tragically.

When asked if Female Patron D had not passed away, whether she would still be recommending thirty days, the Liquor Inspector responded that this information would not have come to her office if the woman had not died. Asked again if her recommendation would stand if the woman had not passed away, she stated that it depends on the circumstances. She was asked if there was the same level of intoxication, the same video and then that is the end of the evidence and nothing beyond is known, the Liquor Inspector agreed that there would definitely be a penalty and perhaps she would recommend the same. She referred to her earlier statement about struggling with coming up with a number. The Liquor Inspector then agreed that the penalty (without the subsequent death) would possibly be much less, maybe within the range specified in Schedule 4 of the *Regulation*.

The Liquor Inspector said that she was unaware whether this amount of 30 days had ever been imposed. She had not ever heard of it for this type of contravention but stated it was possible. She agreed that, prior to this incident, the Pub had no infractions and was not a problem establishment.

Licensee's counsel referred to a memorandum from the branch registrar (obtained through FOI, not entered as an exhibit), which includes a statement about the branch's interest in this case. The Liquor Inspector agreed that the branch's intention is not to look at the cause of death but the behaviour and the action of the Licensee.

The Liquor Inspector agreed that there is nothing within the Serving It Right manual to suggest when it is appropriate to call an ambulance. When asked if there was anything in the Serving It Right manual to teach people about the potential risk of alcohol poisoning, she commented that, as a liquor inspector, if she had been there she would have called an ambulance. The Liquor Inspector admitted that she was highly trained and that she was aware that women can be more affected by alcohol than men. She agreed that there are probably many people who are unaware of the fact that women are more affected by alcohol than men. She agreed that one of the things licensees and staff are advised to do in the Serving It Right manual is to ensure intoxicated patrons have a safe way home or to another place where they can sober up.

With respect to the level of consciousness of Female Patron D in the Pub**,** the Liquor Inspector said she based her conclusions on the coroner's report which stated that Female Patron D had already lost consciousness in the Pub. She agreed that the only source of evidence of this for the coroner was the video. She agreed she had read the transcript of Female Patron B with respect to her communicating with Female Patron D in the cab. She acknowledged the coroner was not being called for this hearing.

When asked if she agreed that immediate steps to be taken would include calling a cab, the Liquor Inspector stated that, as soon as Female Patron D showed strong signs of intoxication, liquor should have been removed. This should have only taken five minutes to wrap things up and remove the patrons. Serving a coffee is not one of the steps she would expect to be taken. Intoxicated patrons must be removed, outside of the red-lined area. A staff member could have been assigned to watch over them until a safe ride was arranged. The Liquor Inspector agreed that immediate action would include asking the table to leave. She did not expect them to be picked up and moved out. She agreed that one step would be to call the police. She agreed that immediate steps would include clearing the table but stated that was not done.

When asked if she were to hear evidence that these steps were taken, whether such evidence would affect her recommendation of 30 days, the Liquor Inspector stated that she would consider it.

The video indicates that Female Patron B was still drinking and the Liquor Inspector said this is also confirmed by the transcript evidence of Female Patron B who stated that she was drinking the wine left on the table by Female Patron D. When asked if she knew if Female Patron D drank any more after she showed obvious signs of intoxication, the Liquor Inspector said she did not know.

The Liquor Inspector agreed that, when this matter first came to her attention, there was some concern that potentially there might be both criminal liability and civil liability on the part of the Pub. She was aware that the police did not charge the Pub or any individuals with any offence. She was aware that there was some discussion about an inquest and the coroner decided not to hold an inquest.

She agreed that Female Patron D did not consume any beer before going to the Pub and that the statement in the NOEA indicating this is not accurate. The Liquor Inspector agreed that Female Patron B stated that Female Patron D did not consume any alcohol before going to the Pub and that this is recorded in the transcript evidence. The Liquor Inspector reviewed the audiotape of the interview, but stated that Female Patron B's memory was somewhat impaired. The Liquor Inspector, therefore, left it as an option that Female Patron D might have had a beer before she went to the Pub.

The Liquor Inspector agreed that she noted the observations made by both Female Patron B and Male Patron A that Female Patron's D's onset of intoxication was sudden, but the interviewing police officers noted that the two patrons could not remember how Female Patron D exited the establishment. The Liquor Inspector stated that it is clear the two had some recollection but it was not all accurate. She noted that Female Patron B's comments about the timeline of events were not accurate.

She agreed that her note in the NOEA of 11 interactions with table 36 does not mean she is alleging that alcohol was brought to the table. The Liquor Inspector agreed that it is reasonable to assume that most of those interactions were arranging for them to leave, pay their bill, and lessen any confrontation.

The Liquor Inspector agreed that the videotape of Male Patron A walking into the beer and wine store does not show any signs of impairment. She agreed that she could not discern any signs of impairment in the three patrons when they are seen leaving the bar on the video. The Liquor Inspector agreed that there is no evidence, that she is aware of, that the other three patrons showed any overt signs of impairment.

When asked about efforts to locate the three patrons, the Liquor Inspector said that this was handed over to investigators in Vancouver and she was not responsible at that point to continue to look for them. She did not make it her responsibility to follow up on that task. She would have turned it over to the branch advocate at that point.

When asked about the Licensee failing to do anything else, other than the over-service, the Liquor Inspector noted that some staff did not have their Serving It Right certificates at the time.

The NOEA refers to 25 shooters. The Liquor Inspector agreed this should read 24 shooters, based on the items listed in the Checks Reports. She agreed that Female Patron B was drinking some vodka and cokes which are included in her total count of 24 shooters. The Licensee's counsel suggested other witnesses gave evidence that there were only four rounds of shooters brought to the table. The Liquor Inspector agreed that she made no attempt to identify in the NOEA exactly what Female Patron D drank. When asked if she was able to break down exactly what Female Patron D drank, the Liquor Inspector said that she was the only one drinking white wine and there was some evidence that she was drinking some shooters. She stated that, when reviewing the amount of liquor consumed by Female Patron D, it is not the dollar price on the sheet,

but rather it is the amount she actually drank and how she metabolized it that resulted in her level of intoxication at the Pub.

The Licensee's counsel showed the Liquor Inspector Exhibit 3 (the receipt showing that the bill was paid at 18:43) and asked if she agreed that anything served to that table had to have been before that time. The Liquor Inspector agreed that it is unlikely that anything was served after that time, assuming that 18:43 is an accurate time. She agreed that Female Patron B paid the bill at approximately 18:43 and that there would have been some time prior to getting that bill and, therefore, it is reasonable to assume that last service was some time before that.

The Liquor Inspector agreed that she relied on the Checks Report (Exhibit 1, tab 11) showing a time period of 4:30 to 7:05 and a time period of 2:44 to 4:21 for her documentation of drinks served.

Transcript Evidence

As noted above, police officers interviewed the three patrons present at the Pub on August 27, 2011. None of the three patrons testified at the hearing. In addition, the police interviewed two of the servers at the Pub (Server 1 and Server 3 who also testified at the hearing), and a paramedic. The police taped and transcribed the interviews and sent them to the branch (Exhibit 1, tab 15).

Interview with Male Patron A (transcript at Exhibit 1, tab 15 (a))

Police Officer B interviewed Male Patron A on October 28, 2011, two months after the date of the incident. According to the transcript, Male Patron A could not remember the name of the deceased woman. He recounted the events of the night when he was awakened by the husband of the deceased.

On the afternoon of August 27, 2011, Male Patron A recalled that he and Male Patron C drank two beers before leaving for the Pub. Female Patron B had a beer and a coffee, and Female Patron D had nothing.

In the transcript, Male Patron A reviewed what he could remember of the time spent at the Pub. He could not remember carrying Female Patron D out of the Pub, even after watching the video. He thought they had only two servers, they settled the bill with the first one and then the second server took over. He believed Male Patron C and Female Patron B split a bill near the end of their time in the Pub.

Male Patron A said that, at the Pub, Female Patron D was the only one at the table drinking wine and she probably had four shooters. He said they were talking about going back to the apartment and barbecuing burgers. He had no recollection of being told to leave. He had no recollection of going to the beer and wine store. He thought they were leaving because they were going home for dinner. He could not remember anyone telling them to leave, or that they would be served no more drinks.

With respect to the level of intoxication of Female Patron D, he stated that she seemed fine up until the time they started talking about going home for dinner. He said she went from being merry after a few drinks to being intoxicated. He reiterated later in the interview that the change happened very quickly.

He remembered Female Patron D vomiting a little in the cab and the cab driver getting upset. He remembered carrying her into the apartment. Male Patron A could not remember if she was completely unconscious or not at the apartment.

In the transcript, Male Patron A stated he was drunk but he was not on the verge of unconsciousness. He admitted that he has forgotten some of the evening's events, partly because he was drunk at the time and because of the two month time lag. After returning from the Pub, he watched TV for an hour or so, felt he was functioning fine. Female Patron B went down to their car. Male Patron C had come out of the bedroom after putting his wife to bed and gave them a spare key to the apartment and then said he was going back to bed.

Interview with Female Patron B (transcript at Exhibit 1, tab 15(b))

Police Officer D interviewed Female Patron B on October 28, 2011, two months after the incident.

According to the transcript, Female Patron B said she had worked as a bar manager for about seven years. She explained how she and Male Patron C had become friends and he had invited her and her boyfriend to visit him and his wife in Victoria.

She confirmed that she and Male Patron A arrived at the home of Male Patron C and Female Patron D about 2:00 p.m. on August 27, 2011. She said that Male Patron C and Female Patron D had consumed no alcohol at all at the time of their arrival at the apartment. Before going to the Pub, the two men drank two beer and she had a coffee and a beer, and Female Patron D had nothing.

At the Pub, she thought Female Patron D was drinking white wine. Female Patron B remembered Female Patron D saying that she didn't like draft beer. There were only 3 beer glasses on the table. She stated they ate nachos, probably close to 6:00 p.m. and that Female Patron D ate most of them. They had shooters after 5:00 p.m. She said everything was going really well. Female Patron B stated that she herself had at least four shooters and four vodkas and cokes. She remembered that Female Patron D downed her shooter, even taking one before the others. It was probably the last round of shooters. She remembered admonishing her, saying it was etiquette to wait for the others to drink.

In the transcript, she said that all of a sudden Female Patron D appeared really intoxicated. She was amazed at how sudden the change was, as they had only had four shooters. And then she said they realized they better get the bill. Female Patron D was reaching for her last glass of wine and Female Patron B took it away from her and spoke to staff, saying this woman's really intoxicated. She went to sit beside her at that point. When asked if many minutes had elapsed before she moved to sit beside her, she said that, when it occurred to her that Female Patron D was impaired, she moved to

sit beside her. She believed she probably asked for the bill. She thought she may have drunk the rest of Female Patron D's wine, which was about half full.

Female Patron B stated that the sudden change in Female Patron D surprised the bar staff too. She stated that Female Patron D went from happy to drunk. Female Patron B continued to emphasize how sudden the change was.

Female Patron B stated she was amazed that Female Patron D died of alcohol poisoning, because she drank the least except for the shooters. She said Male Patron C was surprised too. He told her that Female Patron D was not a big drinker. When Female Patron B was asked if she felt pretty intoxicated, she thought if there were just the three of them sitting there they would not have been cut off.

According to the transcript, Female Patron B said she paid her bill and gave the receipt to the police officer (Exhibit 3). She said she split the total with Male Patron C and her share was $111, including a tip of 14 or 15 dollars. She stated that Male Patron A had paid a bill of about $60 at about 5:00 p.m. She thought this would have been done with the previous server. She said they had three servers, one female first and later a female and a male.

Female Patron B thought they asked staff to call a cab and that it arrived in about 20 minutes. She thought she helped Female Patron D to walk out and that she was still able to walk. She guessed that they would have left at 7:30 p.m. at the latest. She stated that Female Patron D did not vomit much in the cab, just threw up a little into a paper towel, which Female Patron B then put in her purse.

At the apartment building, she stated she was helping Female Patron D walk but once in the building she seemed unable to walk, so Male Patron A carried her up to the apartment. He laid her face down on her bed, fully dressed. She stated the three of them were functional. Both she and Male Patron A felt fine.

When asked if it ever occurred to her to call 911, she said no. She thought that Female Patron D would be okay, that she would just sleep it off. During the interview, Female Patron B watched the videotape and saw Male Patron A carrying out Female Patron D. According to the transcript, Female Patron B then said that if she had been working she would have called 911. The change in Female Patron D's state was so fast that even if she'd been working, she probably would not have red flagged her. She guessed that Female Patron D was someone who barely touched alcohol**.** Female Patron B stated that her tolerance is a lot higher. Her comment was: "I didn't think in a million years that someone could get alcohol poisoning from that amount of alcohol—4 glasses of wine and 4 shooters."

She didn't remember anyone in the group drinking a Crispy Crunch. She thought a Crispy Crunch has Frangelico and possibly crème de cacao.

Female Patron B said the Pub staff tried to suggest that they leave while waiting for the cab. The server said people were starting to stare and that they couldn't have her (Female Patron D) in the Pub in her state. Female Patron B told the server that they would wait inside for the cab. She agreed it was possible that the server told them they were cut off and that they had to pay the bill.

When they left the Pub, she said Female Patron D was mumbling.

She said that Male Patron C gave them a spare key to the apartment after they returned from the Pub. She said she was still wide awake and that she drank a Palm Bay cooler back at the apartment. She went back outside to their van to do a few things and then Male Patron A came down to get her. She and Male Patron A went to bed about 11:00 p.m.

At about 2:00 a.m., Male Patron C woke her up in a panic, saying he had 911 on the phone and that Female Patron D was unresponsive. She stayed with Male Patron C as he continued to do resuscitation efforts until the paramedics arrived. Male Patron A went downstairs to ensure the doors were open for the paramedics.

Interview with Male Patron C (transcript at Exhibit 1, tab 15(d))

Police Officer F interviewed Male Patron C on November 21, 2011 in a town in Alberta where Male Patron C went to live after his wife died.

According to the transcript, he stated his wife (Female Patron D) was very health conscious. He described her as “a health freak” and that she did not do drugs. She was not a drinker—she might have had a couple of glasses of wine on a Saturday night, and maybe a glass of wine with a meal, two at most. He had seen her drunk maybe five times in the five years that he had known her. He stated that when she hit the “drunk mark”, she became drunk pretty quickly.

Male Patron C had a hazy recollection of the night of August 27, 2011. He had just come off a week of night shifts and had slept that morning from about 7 until 12:30. He thought Male Patron A and Female Patron B arrived at about 2:30. He and Male Patron A drank two beers before heading to the Pub. He stated that Female Patron D did not drink anything before they left for the Pub and nothing after they got home.

At the Pub, he said Female Patron D was drinking wine. He remembered at least three pitchers of beer coming to the table, then a couple of shooters and then Female Patron D eating nachos. After that, things got blurry for him. He remembered Female Patron D drinking at least two shooters and at least three glasses of wine. He remembered they ordered at least three sets of four shooters. He remembered rumours about their total bill at the Pub being $280, but he could not remember this himself.

In the transcript, Male Patron C stated they were not asked to leave the Pub. He said it was a mutual decision of the group to leave. He said Female Patron D was looking tired. He said there was no way that Female Patron D could walk home, so he remembered getting into a cab. His memory as to who was sitting where was vague. He thought he got into the cab, maybe putting his wife between himself and Female Patron B.

He said he was confused about when they left the Pub. He said the coroner had told him she was carried out of the Pub and he saw it on the video, but could not remember this.

He remembered Male Patron A picking up his wife when they got to the apartment and helping her from the cab to the apartment. He said he and Male Patron A both assisted her to the apartment. He remembered his wife telling him she was tired. He said she was mumbling and babbling when they went up to the apartment. He said Male Patron A placed her on the bed and rolled her on to her stomach.

In the transcript, Male Patron C stated he went to sleep once he lay down on the bed and, the next thing he knew he woke up to find his wife unresponsive beside him. When he went to sleep, she was lying on her stomach but when he awoke, he saw that she was lying on her back.

Interview with Paramedic (transcript at Exhibit 1, tab 15 (c))

Police Officer B conducted an interview on October 28, 2011, with the Paramedic who attended the residence in the early morning hours of August 28, 2011. The Paramedic did not testify at the hearing.

According to the transcript, the Paramedic was with the advanced life support crew and arrived at the residence of Male Patron C and Female Patron D about 2:00 a.m. on August 28, 2011. He said the fire crew was there and had begun resuscitation efforts (CPR). Because CPR had been initiated, he took over for a few minutes and then

assessed that she had some advanced and prolonged signs of death, so they stopped their resuscitation efforts at that time. He estimated she had died about four hours prior to their arrival.

When asked about signs of intoxication in the husband (Male Patron C), he did not recall smelling alcohol nor did he notice slurred speech. He did not make a note about Male Patron C's level of intoxication.

Interview with Server 1 (transcript at Exhibit 1, tab 15(e))

Police Officer E interviewed Server 1 on March 22, 2012. At the date of the hearing, Server 1 no longer worked at the Pub. She did not testify at the hearing.

According to the transcript, on August 27, 2011, Server 1 started work at 10:30 or 11 a.m. and finished at 4:00 p.m.

She remembered table 36 and said she served them a jug of beer and that one of the women ordered a glass of white wine. Server 1 said they were all sober when they entered. She brought them another round of wine and beer and, not long after that, there was a shift change. Another server, identified as Server 2 in this hearing, took over.

In the transcript, Server 1 said she has had no specific training about intoxication, just the Serving It Right training and experience from cutting off people that she has learned along the way. She said bussers learn by watching the servers at work, and after maybe a year or more, they end up being a server.

She said the Pub was a good place to work and that she had been there for seven years. There was decent support from management. On August 27, 2011, she probably left around 4:45 p.m. and said the table seemed totally fine. The four were just laughing and talking.

Interview with Server 3 (transcript at Exhibit 1, tab 15(f))

On February 14, 2012, Police Officer C interviewed Server 3, who also gave evidence at this hearing.

According to the transcript, when Server 3 started work at 5:00 p.m., the four patrons were sitting at table 36. There was only a jug of beer on their tab. She said they were very nice, quite loud and funny. Female Patron D had been drinking wine; she was not drinking beer. Male Patron A ordered a few rounds of shots. She said she was gauging the liquor amount served and everything seemed to be fine. She brought four rounds of shots in total to table 36. She said they each had four shots over two hours. One woman (Female Patron B) was ordering vodka/coke. The other, Female Patron D, was nursing a couple of glasses of wine.

Server 3 said she chatted with the woman (Female Patron D) several times when she stopped her as she was walking by. She heard her talk and said she was able to converse clearly. She said the change in her was instant—it wasn't a slow progression. Everything seemed fine and then, all of a sudden, she was intoxicated. Server 3 remembered only bringing four shots, four rounds of four. She said they bought her a couple of shots as well.

She said that at one point, almost instantly, something changed in her (Female Patron D). Server 3 said that one moment she noticed her slurring her words and, 20 minutes after first noticing her, they were gone from the Pub.

According to the transcript, when she first noticed the signs of intoxication, Server 3 told the Bartender that she was cutting them off. The Bartender told her to call a cab and to get them out of the Pub. When she cut them off, she said that Male Patron A became quite angry. She said Female Patron D stood up and then she couldn't stand and "her husband" (sic) kind of helped. It went from four people having a good time to three people having a decent time and this "one woman was just annihilated—like really really drunk." She thought she asked them to leave around 7:00 p.m.

Server 3 thought the other three patrons were still all right. She said she may have tapered off with them, but then the Bartender told her they had been there all day. This was the first she had heard of this, except for the jug of beer that was on the tab when she took over. She didn't know they had had anything else. Server 3 said they would have paid the previous server and then everything they had would have been wiped off the system. She said it was just a real lack of communication. She wondered why no one had told her that they had been there all day. She said it would have helped if she had known that beforehand.

The three others seemed fine, loud but not obnoxiously loud. In the transcript, Server 3 said they were all having fun and then everything happened pretty quickly. Female Patron D was bent over on the table and leaning against "her husband." The others were functional. When Female Patron D stood up and started to walk, Male Patron A came and lifted her up and put her in the cab.

Asked if she thought she over-served them, Server 3 agreed that she had, and then added that she has served that amount of alcohol to other tables. She said the Serving It Right manual suggests two drinks an hour.

When she cleaned the table, there was one full shot and almost another shot still on the table.

Video (CCTV) Surveillance Tape of the Pub Interior on August 27, 2011 (Exhibit 2)

At my request, the branch advocates, the licensee's representative and the licensee's counsel, with the three servers who appeared as witnesses for the licensee, viewed the videotape with the Liquor Inspector showing a shortened portion of the afternoon and making brief comments.

There were two closed circuit video cameras in the Pub. One camera captured people as they were entering or exiting the Pub and the second captured a corner of table 36 where the four patrons were sitting on August 27, 2011. Female Patron D is visible most of the time as she is sitting at the corner which is captured on the videotape.

The Licensee initially objected to the inclusion of tab 17 in the branch Book of Documents. Tab 17 is a record of the observations of the Liquor Inspector from watching the videotape, with times noted. The Licensee eventually agreed that the whole of the branch Book of Documents be marked as an Exhibit (tab 17 included). I stated that I would rely on my own observations of the videotape to verify any statements made by the Liquor Inspector about what she observed on the videotape and to draw my own conclusions about the signs and symptoms of intoxication shown by Female Patron D.

I observed the videotape at the hearing as noted above. After the hearing, I observed the videotape again on my own. I note here that the CCTV videotape marked as Exhibit 2 requires a Windows program to view, and that copying to the hard drive of a computer increases the speed of access.

I reviewed the detailed notes of the Liquor Inspector's observations at tab 17. I concur with her note at 18:25 that this time marks the beginning of Female Patron D's signs of impairment. Prior to that time, there are notes about her skirt sliding up and arms moving at 18:01 and again a note at 18:03 about "using hands more while talking." For comparison, I observed the table beside table 36 with a group of people (more visible than table 36) and noted how, as people were talking, hands were used at different times and bodies shifted in their seats, none of which are conclusive indications of intoxication.

I observed the nachos being brought to table 36 at 17:20. At 17:39 and 18:11, Female Patron D appears to be consuming a shooter. At around this time, there are several hugs from the person to her left. At 18:18, she appears to be consuming and again at

18:19. It is difficult to determine if she is consuming a shooter here or something from her wine glass. At 18:25, Female Patron D lies back in her chair and extends her legs straight out and quite open, in what one might consider a socially inappropriate way. From this time, she progressively shows increasing signs of intoxication, begins to lay her head on the table and is having great difficulty staying upright.

I observed Server 3 interacting with Female Patron D at 18:22. At 18:30, Female Patron B moves to sit beside her. Female Patron B is now visible on the videotape. Female Patron B reaches for her wallet at 18:34. At 18:42, Server 3 is at the table and Female Patron B can be seen putting away something in her wallet, probably her receipt. At 18:49, Server 3 can be seen kneeling down beside the table, talking to Female Patron B. At 18:52, Male Patron A picks up Female Patron D and carries her from the Pub. The camera at the entrance of the Pub shows her being carried out at 18:54.

I observed the short section of videotape from the camera mounted in the beer and wine store and could see the beer and wine store employee and Male Patron A at the counter. According to the later testimony, Male Patron A was refused service. I could not observe any signs of intoxication in Male Patron A.

EVIDENCE- THE LICENSEE

The Licensee called six witnesses, including one expert witness.

The Physician

The Licensee called the Physician to testify as an expert in emergency room practice. He practises at Victoria General Hospital. The Physician did not prepare an expert report for the hearing. The Licensee provided notice to the branch that they would be calling this witness as an expert.

Licensee's counsel asked that I qualify the Physician as an expert in the area of emergency medicine. The branch had no objections to this. I therefore qualified him as an expert in this area.

The Physician reviewed his experience and resume (Exhibit 5). He received his MD in 1986. He has been medical director for the provincial air ambulance and critical care program since 2006. He has provided flight medical advice for paramedics since 1996. He was medical director of Emergency and Trauma Services for Vancouver Island Health Authority from 2005 to 2009 and director of Trauma for Vancouver Island Health Authority from 2001 to 2009.

Licensee's counsel asked the Physician about his experience with treating patients with alcohol poisoning. The Physician testified that he encounters intoxicated individuals regularly on his shifts and may have several on each shift. He works in the emergency department at night. Intoxicated people are usually brought in by friends, family or an ambulance. He has never, in his knowledge, received a patient directly from a drinking establishment.

The Physician stated that alcohol intoxication results in physiological changes to the nervous system, and that it operates on a continuum. An individual will start to have altered consciousness and may proceed from being mildly intoxicated to extremely intoxicated, which can result in the individual not protecting his/her airway reflexes.

He has observed people with a high level of blood alcohol. Their ability to function and converse varies. The Physician testified that he has observed highly intoxicated people who don't necessarily show typical symptoms of intoxication. He has seen people awake and talking with very high blood alcohol concentrations. He has seen 900 mg% in some alcoholics. Often people with up to 300 or 405 mg% still appear to be functioning.

Asked if there are any tests to distinguish between intoxication and alcohol poisoning, the Physician stated that the hospital tests for intoxication and that the doctors do not use the term alcohol poisoning as a medical term.

The Physician stated the treatment for intoxicated patients who arrive at the hospital is to put them in bed and roll them on their side. If there is reason for concern that their condition is not due to alcohol, they may start tests. If it is fairly clear that their condition is due to alcohol, they allow them to lie on their sides until alcohol has been metabolized.

When asked when he thought it advisable for a layperson to call an ambulance, he stated that it is highly dependent on the circumstances. When asked if a person were being carried to a cab, the Physician said his question would be whether that person was completely unconscious. He would recommend calling an ambulance if the person was not responding at all. The reaction of any one individual to alcohol will depend on a number of factors: weight, gender, other drugs in their system, any food in the stomach.

When asked if he had read the article about fatal alcohol intoxication in women from Slovakia (Exhibit 6, tab 3), the Physician stated he read the abstract, the background and the conclusion. He did not go through all the methods. He agreed with the statement in the article that women have a lower activity of enzymes that takes longer to absorb alcohol. The same amount that a man drinks as a woman will have a higher effect on the woman. Overall, he agreed with the statement about the higher sensitivity of women to alcohol.

The Physician said he agreed with the following (page 2, tab 6 of Exhibit 6) as a general statement:

> Most people, and young people in particular, are not aware that just one occasion of severe alcohol intoxication can cause very serious problems, including gastrointestinal bleeding, abnormal heart rhythm (arrhythmia), stroke (cerebrovascular accident or CVA) and respiratory depression that can lead to death.

He agreed with the statement, also on page 2 of tab 6 of Exhibit 6, that some people are more vulnerable than others because of biological or genetic reasons and that, in such people, a number of conditions may be brought on by a relatively small amount of alcohol.

When asked if he thought it beneficial for servers to be taught this information, the Physician said he had not put a lot of thought into it, but it is probably a good idea.

The Physician testified that he agreed that the descriptions of moderate intoxication (BAC 50 to 150 mg%) and the descriptions of severe intoxication (BAC 300 to 500 mg%) as set out at page 140 of tab 7, Exhibit 6, were reasonably accurate. He agreed that people pass from moderate to severe showing the different symptoms and that this was a continuum. He agreed that some people may pass from moderate to severe quickly.

When intoxicated people are brought to emergency, the hospital staff observe them to see if they might be exhibiting the severe signs of intoxication. He agreed that staff in a liquor licensed establishment can only observe people in this state while they are on the premises.

The Physician was asked to comment on the article at tab 8 of Exhibit 6, in particular the second paragraph of page 2, which states:

> Decreased “first-pass metabolism” combined with a smaller volume of distribution may explain the enhanced vulnerability of women to acute complications of alcohol intoxication.

The Physician explained that when one drinks a glass of alcohol, it begins to be broken down by enzymes in the stomach. The rest is absorbed in the bloodstream; the blood goes to the liver where it will metabolize. This is called the “first pass” effect, going through the liver before being distributed in the body. He agreed that the “first pass” effect is greater in women, which means that a woman of the same weight as a man and drinking the same amount will likely have a higher blood alcohol level and possibly greater symptoms of intoxication. He said that a man’s ‘first pass’ effect is 80% while a woman’s is 95% meaning more alcohol passes into the bloodstream in the woman than the man.

The Physician said he had not read the Serving It Right manual. However, he agreed that it would be useful to include information that women are more susceptible to alcohol and that there should be information about breathing effects to watch for in overly intoxicated individuals.

Cross-examination

On cross-examination, the Physician agreed he was provided with the coroner’s report (tab 21 of Exhibit 1). He was asked to explain what “lethal ethyl alcohol toxicity” means. The Physician assumed it meant depression of the respiratory system from alcohol toxicity. He stated that what is unknown is what actually killed her, i.e. was it asphyxiation from rolling on her back and depression of respiratory system or was there a cardiac event? He couldn’t tell from what was stated in the coroner’s report. When asked if he agreed with the immediate cause of death, as stated, he said absolutely, there was abuse of ethyl alcohol.

The Physician said he had reviewed the toxicology report at tab 22 of Exhibit 1, but did not prepare a written opinion on these results. He did not prepare a written opinion on any of his testimony.

He agreed with the following statement at page 4 of tab 8, Exhibit 6:

> When the BAC exceeds 0.30 percent, stupor and loss of consciousness can occur. Some patients experience coma and respiratory depression, and death is possible.

In response to a question about training of the licensee's employees, the Physician agreed that the Licensee did not provide him with any information about their training.

Server 3

Server 3 was the main server for table 36 on August 27, 2011. Server 3 testified that she started working at the Pub as a busser. As a busser, she carried food, cleaned tables, took payments, and generally offered support to servers. She did not serve liquor.

Server 3 testified that, in August 2011, she asked her manager if she could start working as a server. By August 27, 2011, she had been working as a server for maybe two or three weeks, with about one or two serving shifts a week. She continued as a busser on the other shifts.

Server 3 stated she had received on-the-job training at the Pub, working with servers for several years and shadowing shifts with servers who taught her how to multi-task. She attended staff meetings where topics discussed included dress code, promotions in pub, and keeping everyone up to date.

When asked if there had been any issues raised about over-service, Server 3 said none. She understood the policies on how to deal with intoxicated patrons: work in the best interests of someone who is intoxicated, call a cab and make sure they get home safely. The beer and wine store was notified if there were any concerns about someone's level of intoxication and staff there were advised not to sell liquor to that person.

When she calls a cab for patrons, Server 3 said she watches them to be sure they get into the cab. When asked if she had ever observed people actually trying to get into their cars when they shouldn't be, she said she had and that, if this happens, she tells them that the Pub has their license plate number and staff will call the police. As the beer and wine store looks out onto the parking lot, the Pub staff will tell the store staff when someone is cut off and ask them to let the bartender know if they see the person trying to get into their car.

Server 3 testified that, on August 27, 2011, she started work at 5:00 p.m. There were two women and two men seated at table 36. Server 2 asked her to take over table 36. There was only a jug of beer on the table. The Pub was not very busy.

Server 3 agreed she had watched the videotape (Exhibit 2) prior to testifying. She recalled serving another jug of beer. One woman at table 36 was drinking vodka and diet cokes and the table was ordering shooters. She thought she brought maybe 2 or 3 vodkas and cokes. Female Patron D was drinking wine. Server 3 believed she drank three glasses of wine.

When she first took over, the table ordered a round of shooters and then three more rounds after that. Server 3 stated she is positive she served them four rounds of shots. When asked about the bill and the fact that more than four rounds were on the bill, she stated that every time table 36 ordered a round, they would try to buy her a shot. She said she could not have one then, but the Bartender told her it was okay to drink them when her shift finished. She therefore added them to the bill. She explained that a crispy

crunch is a mix of different alcohols, one ounce of hard liquor. The patrons at table 36 were intending for her to drink them. She stated that she definitely did not consume them. She explained that Grey Goose (noted on the checks reports) is a premium vodka.

Server 3 said she did not recognize the checks reports at Exhibit 1, tab 11, as the screen the servers use does not show the information like this. She explained that the seat numbers shown on the checks reports at tab 11(ii) and (iii) show how she separated the bill, as requested by the patrons.

She remembered that Female Patron D did not finish all her wine because she complained it was getting too warm from the stemless glasses. Server 3 thought that there were maybe the equivalent of two glasses left over. She said she had thought about discounting them because she was throwing away a lot of the wine.

Server 3 stated that the amount served to table 36 was not uncommon. She has observed others drinking this amount. She said it would not be an issue for friends of hers or co-workers to drink that much. Since the incident, she has become very cautious about the amount she serves.

She served the nachos, but did not know who was eating them. Server 3 observed the table regularly, stopping to chat and making sure they had everything they needed and that they weren't getting intoxicated. She observed the four of them laughing, telling stories, and generally having a really good time.

She remembered the last round of drinks. Male Patron A wanted to try a better vodka so she served him the premium vodka, Grey Goose. He said he didn't see a taste difference, so he wanted to go back to the cheaper price. Server 3 had this conversation with Male Patron A just before the last round.

During the last round, she stated that Male Patron A was arguing with her about the drinks. He wanted the premium vodka instead of regular vodka, but at the same price as the regular vodka. The Bartender told her to just give him what he wanted and then give him the bill. Server 3 said he was frustrated that she hadn't given him a discount. She felt he was starting to be rude so she gave him the bill. She said the Pub does not put up with rudeness to the servers.

She saw Female Patron D talking to her friend, both of them laughing and giggling. Server 3 stated that no one was exhibiting signs of intoxication. There was no slurring, no staggering when standing, no indication to her that anything was going on that needed to be controlled.

Server 3 was asked about the table of regulars next to table 36 who were looking over at table 36 in the video. She said the one guy, Male Patron A, was being a bit noisy about the bill. One of the male patrons paid the first bill (first for her as the server) and Female Patron B paid the second. She said there was about 8 to 10 minutes between the two paying the bills. She said she had to ask Female Patron B to pay the bill because either the cab had arrived or was about to show up.

Server 3 testified that she noticed signs of intoxication in Female Patron D when she had her head down on the table. This was her first indication that anything was wrong. Female Patron D was wavering back and forth and her friend had to support her. Server 3 said she called the cab. The Bartender was off the floor briefly and returned to see Female Patron D with her head on the table. The Bartender told Server 3 to remove everything from the table and to tell them to leave. She remembered removing one full shot of vodka and a glass with some wine. Server 3 then kneeled down and asked them to wait in lobby for the cab and apologized a few minutes later when the cab came. They refused to wait in the lobby.

She said Female Patron D's signs of intoxication were not gradual, that the change happened very quickly. There was no indication to her or to anyone else in the Pub that Female Patron D had consumed too much until she put her head down. When asked if she was concerned, she replied "Incredibly, yes." Female Patron B told her that she had clearly over-served Female Patron D. When Server 3 asked if Female Patron D was okay, Male Patron A said she was.

When the cab arrived, one of the males picked up Female Patron D and carried her into the cab. When he helped her up from the chair, he handed Female Patron D to Server 3 and to Female Patron B and then gathered her things. When Server 3 asked Male Patron A to help, he then picked her up. She had left a shoe so Server 3 gave this to one of the males. She watched them help her get into the cab. She watched Female Patron B get in the other side of the cab.

When asked about Female Patron D's level of consciousness, Server 3 said she was conscious when Male Patron A picked her up and that she was moving around in the cab. When the other three patrons were leaving, Server 3 said they were fine. The three were walking and talking fine, not slurring their words. There was no indication from them that they had had too much to drink. Male Patron A did not appear to have any difficulty carrying Female Patron D from the Pub.

Server 3 said she did not know how many shooters Female Patron D drank. She was aware that one of the male patrons went to the beer and wine store. The Bartender had instructed staff there not to serve him.

Since the incident the Pub has made some changes. Server 3 said the main change was an improvement in communication. When a server takes over a table from another server, the bill is printed so the new server knows exactly what was on the bill. In addition, she said staff are very cautious about not letting patrons get intoxicated. She said they always ask patrons if they are driving home, and will offer a cab, etc.

Server 3 said there have been lots of staff meetings to make sure everyone is on the same page. Everyone is being very diligent about service and being mindful of the tables. She said the Pub has always been a great place to work and that all staff want to keep it that way.

When asked about her own changes since the incident, Server 3 replied that she has become the most cautious of the staff, as she does not want anything like this incident to ever happen again. She says her co-workers tease her because they think she is overly cautious. Even if a patron does not look drunk, she will cut them off if she thinks they have had enough.

When asked about the Serving It Right certificate, she said she obtained it on August 31, 2011, four days after the incident. She had only been a server for a few weeks. As a busser, she wasn't serving alcohol. She took the test online after reading all the materials. Asked if she learned anything that might have affected what occurred on August 27, 2011, Server 3 replied probably nothing, because there was nothing in the materials that gave her a solution to what had happened. She reviewed the signs of intoxication in the manual but, in the August 27, 2011 incident, she observed none of these signs until the very end of the patrons' time in the Pub. She said the Serving It Right manual talks about weight and how this might affect different people, but she couldn't remember anything about gender differences. She said the manual indicates 2 to 3 drinks an hour as an average to serve.

Server 3 said she observed no signs of impairment when she delivered the last round of drinks to table 36. She said she would not have served anything if there were signs that Female Patron D had too much to drink.

When asked what was her understanding of what to do when someone is obviously impaired, she replied that she calls a cab to make sure they get home safely. She stated that if one person is cut off because he/she is showing signs of intoxication, no one else at the table can have a drink until that one person is safely out of the Pub.

When asked what else she has learned to assess sobriety, Server 3 said she always talks to people and listens to their conversations.

When asked if she learned anything from Serving It Right with respect to alcohol poisoning, Server 3 stated she has learned since and has obviously seen what it looks like. She said there is nothing in Serving It Right about calling an ambulance. She did not call an ambulance as none of Female Patron D's friends seemed concerned. Her friends kept telling her that Female Patron D was fine. Male Patron A went to buy more liquor in the beer and wine store.

Server 3 said she has never called an ambulance for a patron. Asked if she would do anything differently, knowing what she knows now, she stated it is hard to know if she would do anything differently. She again emphasized that Female Patron D's friends kept telling her that she was fine. Server 3 added that, if she saw someone like Female Patron D again, she would call an ambulance.

Server 3 was asked what she would do if the Pub were closed down for 30 days and she would not be able to work there. She replied that she does not have another job or other sources of income. She says the tips provide the main income. She said there are other staff who will be worse off than her.

When asked how this incident has affected staff at the Pub, Server 3 said that everyone is very aware of this incident and that they are all genuinely trying to make sure nothing like this happens again. Staff at the Pub treat her a little differently as they try to protect her from taking a table where people may have been drinking for a few hours.

Cross-examination

Under cross-examination, the branch advocate visually displayed a set of shot glasses, jugs used for beer, and wine glasses. The branch advocate set out 3 stemmed wine glasses, 16 shot glasses, and 2 jugs of beer.

Server 3 agreed she served table 36 with four rounds of shots and one jug of beer. In all she remembered serving 16 shots, one jug of beer, 2 or 3 glasses of wine and 2 or 3 vodka/cokes. She agreed the items displayed (with the exception of the stemmed wine glasses, as the wine glasses were stemless) represented the amount served.

Asked about her response to Police Officer C who interviewed her on February 14, 2012, she recalled saying Female Patron D was “annihilated, very drunk.” She agreed she had said that the patrons were over-served on August 27, 2011.

Server 3 said she did not tell anyone at the Pub she did not have her Serving It Right certificate. She gave the manager the number when she was asked for it. She called him a few days later and told him that she did not have it on the date of the contravention. She said that he was shocked.

At the time she started working at the Pub in 2009, Server 3 said there was no in-house written policy about intoxication. She said that she had observed other servers but she had no specific training on this. She agreed that the Licensee had not administered any written tests to check her understanding of intoxication. Server 3 said she, another server, and the Bartender wrote an incident report. She said the Licensee did not review the log book with her.

Asked about staff meetings, Server 3 said they are mandatory and that an attendance sheet is used and they are usually given something that says what will be discussed. She agreed that the subject of intoxication comes up at staff meetings. She does not know of any written minutes of the staff meetings.

Server 3 said she had not seen the Guide (tab 6, Exhibit 1) before.

She said she did not know for sure how many drinks Female Patron D had that day, or how many drinks each person at the table had. Server 3 said she was not paying attention to what each one was drinking; just how much she had served the table. She did not speak with Female Patron D while she was being carried out of the Pub.

Beer and Wine Store Employee

The beer and wine store employee ("Store Employee") testified that she has worked in the beer and wine store adjoining the Pub since April 2011. She generally works the night shift from 5:00 p.m. to 11:00 p.m. and on Saturdays usually from 9:00 to 4:00. She was working at the beer and wine store on August 27, 2011.

She holds a Serving It Right certificate, having obtained it about 3 months before working in the industry. The online training taught her how to request identification of those suspected to be underage, what the signs of intoxication are, and when to cut people off.

The Store Employee testified that she attended staff meetings at the Pub. She was not familiar with any written policies or procedures with respect to preventing impaired customers from purchasing liquor. She said that servers from the Pub would come to the beer and wine store and tell her if they had cut off a patron in the Pub.

The signs of intoxication that she looks for are stumbling, teetering, slurring words, not opening eyes properly, and general smelling of alcohol. If she smells alcohol, the Store Employee asks if they have been drinking. If they say yes, she refuses to serve them.

She remembered the Pub being a little noisy on August 27, 2011, as she could hear a bit of commotion over the wall. A few minutes after hearing some noises from the Pub, a man walked in and tried to purchase beer. The Bartender entered the beer and wine store via the Pub door, a staff only entrance, and made the cut off sign to her. The Store Employee did not observe any signs of intoxication in the patron, other than to note how

angry he became when she denied him service. Prior to refusing him service, he just seemed happy. She did not have an opportunity to smell his breath.

The Store Employee could not recall if she exchanged words with the Bartender, who pointed directly at the customer and made the cut off sign. She believed she exchanged some words with the Bartender after the incident, asking why she was not permitted to serve him. Other than the Bartender's signal, she saw no other reason not to serve him.

With respect to any changes in the Pub since the incident, the Store Employee said she works there one day a week as a busser and has observed that staff are stricter about cutting off people. Staff are more aware of the conditions of their customers; more observant of their customers' actions, attitudes and body language.

On cross-examination, the Store Employee agreed that she was never given any written policy on intoxication when she began work with the Pub and at the beer and wine store. She stated she submitted an incident report. She attends the mandatory staff meetings and said she has not received a copy of an agenda nor any minutes after the meetings. She has not seen the Guide before. She could not recall if this particular incident was reviewed with her and other staff at a general meeting.

Server 2

Server 2 served table 36 for a brief time on August 27, 2011. She no longer works at the Pub, having left sometime in 2012. She started working full time at the Pub in May of 2011. She was hired as a bartender and occasionally worked as a server.

Server 2 testified that, in her time working there, she had not observed over-service in the Pub. She said it was a very quiet pub, very different from places she had worked previously, very tame, which is why she liked it so much. She stated food was more of a priority than liquor. She said she had cut people off once or twice in the Pub.

She started work at 4:00 p.m. on August 27, 2011. Server 2 remembered there were four people at table 36. The previous server (Server 1) settled the tab and she then began a tab with them. Server 2 was not aware of what was on the previous tab. The four appeared to be a typical table, relaxed and having a conversation. She brought one jug of beer to the table during the half hour she served them. About 4:30, she transferred the table to Server 3 and continued with her section the rest of the night. Server 2 did not recall saying anything to Server 3.

She was asked about serving 16 shooters, 5 jugs of beer, and about 6 glasses of wine to a table of four over four hours. Server 2 said, in her experience, this amount was not "extremely" out of the ordinary. She has served people that volume of liquor at other times and has observed the people afterwards. When asked how such people behaved and whether she would cut them off after consuming such a volume of liquor, she said it would be purely situational. It would depend on the person, their size, and whether they ate. She has observed that eating lessens the intoxication signs.

Server 2 said that she walked by table 36 while serving other tables. Table 36 was not in her direct line of focus. She could not recall observing any issues with respect to the people at that table. If she had noticed any issues, she would have spoken with the Bartender to let her know her concerns.

When the four patrons at table 36 were leaving, she saw them stand up but did not see them go through the doors. She saw the one woman with an arm around a gentleman. After the incident on August 27, 2011, Server 2 observed some changes with respect to the operations at the Pub. She said the staff watched more closely and were very diligent with liquor service. She said they started communicating a lot more when they were transferring bills. They showed copies of the bills so the next server could see what customers had consumed. There was a lot more communication between the bartender and servers. Nobody wanted such an incident to happen again.

She was asked about her understanding of the Pub policies with respect to preventing customers from being over-served. Server 2 said, as a bartender, she would watch the service and the amounts of liquor going to each table. She said staff were very diligent about making sure people did not drink and drive. Staff followed people out after calling a cab. Customers were more than welcome to leave their car overnight and leave the key behind the bar.

Server 2 testified that she had not received any training as to when it might be appropriate to call an ambulance. Nor had she received any training in how to recognize alcohol poisoning.

Cross-examination

On cross-examination, Server 2 stated that the Bartender was in charge of the Pub on August 27, 2011, from 5:00 p.m. to closing time.

She had no recollection of being provided with written in-house policies on intoxication and when to remove intoxicated patrons. Nor was she ever given any written tests by the Pub. Server 2 said she wrote in the incident log book about what happened on August 27, 2011.

She agreed the Pub holds mandatory staff meetings and that there is no written agenda, nor a record of the meeting provided afterwards. She could not recall the Licensee ever reviewing the Guide with her.

On redirect, Server 2 agreed there is a bulletin board in the staff area, with schedules and notes from managers, memos, special events, scheduled staff meetings. She agreed there is a copy of the Serving It Right manual in the Pub as she had heard others say that. She has looked at the manual online in past 3 years and agreed that it has policies and directions with respect to the service of alcohol.

The Bartender

The Bartender testified that she was the person in charge on August 27 2011. In 2007, she started working at the Pub as a busser. After about a year or two, she was promoted to a server. She continued as a server and worked as a bartender as well from about 2009. She learned how to bartend from a co-worker. Her current full time position is head server and supervisor and, as such, she is responsible for dealing with staff issues. She does not work anywhere else. She obtained her Serving It Right certificate in 2007 when she started at the Pub.

The Bartender testified that she pours drinks for customers at the bar and for servers when they give her their order. She explained the “squirrel” program which shows the amount ordered to each server, as shown in the checks reports at Exhibit 1, tab 11. She usually casts her eyes over the room to make sure everything is going well, looking for how people are behaving, and observing their sobriety level. If people are sloppy or loud or obnoxious or come up to the bar when she is bartending, she will communicate with the server as to how much that person has to drink. She stated it is mainly the responsibility of the servers to watch the sobriety of the customers.

Asked about the Pub’s policies to prevent over-service, the Bartender said the staff always make sure their customers get home safely. They will watch a customer get into a cab and make sure they do not get into their vehicle if intoxicated, and leave their keys at the bar. They will tell staff in the beer and wine store to watch for a customer, as the staff there can see the parking lot. If someone has been told not to drive and does, staff will call the police immediately.

When asked about cutting off people, the Bartender said that if a customer appears intoxicated, they are cut off. If a customer is already intoxicated when they enter the Pub, they refuse them service. Staff will decide to cut someone off when any of the signs of intoxication appear. If someone is being rude or showing disrespect to a server, he/she will be cut off. Prior to August 27, 2011, she did not observe any over-service when she was working.

The Bartender testified that, on August 27, 2011, she began work at 5:00 p.m. She was serving and bartending. She was in charge of the staff in the Pub and was responsible for making sure everything was going smoothly over shift changes. The Bartender could see table 36 from where she was working at the bar, although there were some obstacles in her view (such as the squirrel machine, the taps, a big post, and a seat for a customer).

She recalled seeing table 36 with four people who looked like two couples. When the Bartender first saw them, she said they seemed fine, having a good time. She had no interaction with the table, but would observe them from time to time. She remembered pouring four shots of vodka for table 36.

She remembered a discussion with Server 3. She said the patrons at table 36 were offering to buy her shots. The Bartender remembered the conversation about the offer of the shots, as Server 3 asked if she was able to ring them in, which she did. She reminded her that she could have them after her shift, as it is illegal to have them while she was working. She agreed Server 3 was new at serving.

She could not remember the other drinks served to that table, other than the four shots. When asked what a Crispy Crunch is, she replied frangelico and crème de cacao. She thought they may have been the shots that Server 3 wanted, but she could not recall. The Bartender did not know that, prior to beginning her shift at 5:00 p.m., Server 1 had been serving table 36, nor did she know what had been served previously. She eventually learned from Server 2 that the group had been there prior to her arrival.

The Bartender was asked to look at the summary of liquor served to table 36 (tab 17(ii), Exhibit 1) over a period of four hours. She said it is not so common to have the rounds of shooters as well as the rest. Over a couple of hours, four rounds might be common. The Bartender stated that this volume of liquor to this amount of people over this period of time might occur several times in a week. Asked about her drinking habits, she

replied that she has had four shots, but over two hours, at a downtown pub once. She did not drive afterwards.

The Bartender recalled Server 3 bringing the last round of shots to the table. She remembered Server 3 telling her that the table wanted another round, but they wanted the Grey Goose for the regular vodka price. She remembered Server 3 saying that one gentleman was being rude to her. She told her, if she was comfortable serving them the last round, she was welcome to then cut them off. She did not recall Server 3 saying anything other than commenting on the one patron's rudeness. The Bartender did not make any observations at that time of the people at the table.

After she poured the last round, she believed that Server 3 then gave them the bill. Around that time, she went to the washroom. When the Bartender returned she saw the woman (Female Patron D) looking extremely intoxicated with her head on the table. Prior to that, she had not observed anything other than they were all laughing and having a good time. She did not observe any others signs of intoxication.

When she saw Female Patron D with her head on the table, she told Server 3 that the lady was extremely intoxicated and needed to leave. She told Server 3 to remove the drinks and watched her do that. The Bartender could not recall if there was any liquor still in the glasses. Server 3 called the cab. Her reaction to Female Patron D was that she had seemed completely fine and then from one moment to the next, she went from "0 to 60."

Asked about her experience with watching people become intoxicated, the Bartender said, normally, she would hear them start to slur their words, maybe stagger a bit, gradually getting drunk. She did not observe any of that in Female Patron D. Nor did she observe any signs of intoxication in the other three patrons with her. She watched them leaving. The male (Male Patron A) carried out Female Patron D and he was able to do so without any staggering. The Bartender did not observe any signs of intoxication in Female Patron B as she watched her leave. She did not speak to any of them.

She believed it was Server 3 and Female Patron B who helped Female Patron D get up from the table. They kept her steady until the gentleman (Male Patron A) picked her up. She said Female Patron D was conscious when they were leaving as she was talking, slurring her words, and had her eyes open. The Bartender said she was definitely impaired. The two (Female Patron B and Server 3) first tried to walk with her. The man picked her up because she could not walk.

The Bartender testified that she watched the two women and the one man get into the cab. As Server 3 had told her that the male (Male Patron A) had said he was going to the beer and wine store she entered from the Pub staff entrance and indicated to the Store Employee not to serve him by making the cut off sign. She thought she may have spoken to the Store Employee. She explained that the Pub's policy is that once a table in the Pub is cut off, all patrons at that table are cut off, including at the beer and wine store.

Asked about changes in the operations of the Pub since that incident, the Bartender said there is more communication between the servers. When a server transfers a table now, he/she will print out the bill and will inform the next server how much a table has consumed. The bartenders are now more aware of what patrons have consumed. She said this was not the practice before August 27, 2011.

The Bartender said she attends the staff meetings and sometimes there may be a handout of what will be discussed, but not always a written agenda. After August 27, 2011, the staff and management discussed over-service and clarified the policy for transferring tables.

Since August 27, 2011, there have been some management changes. The Pub has a new manager as well as a head bartender and a head server. At the time of the incident, there was one manager for both the Pub and the beer and wine store. Now there is a manager for each.

The Bartender is a head server now. Her duties include hiring and firing and training new staff, holding staff meetings, as well as individual meetings with staff. The purpose of the meetings is to stress the importance of communication and to stress the importance of knowing what customers have had to drink. New staff train two shifts with her and then she decides if they can work on their own. She makes sure everyone has their Serving It Right certificate; she double checks this. She talks to new staff about over-service, not to serve intoxicated people, and to make sure a customer is not already intoxicated when he/she comes to sit in their section. She informs new staff about the August 27, 2011 incident and tells them, if over-service occurs, they can be fired.

The Bartender said she has not observed any over-service since the incident. Staff are told to make sure any patrons showing signs of intoxication are not driving. Staff will call a cab to make sure they get home safely and will try to watch them getting into a cab.

The Bartender described the Pub in general as pretty quiet and laid back. She said most people come in to eat. There are not a lot of young customers. She had not observed other problems in the operation of the Pub in the past, except for this incident.

The Pub has a bulletin board, where management posts reminders of things discussed in staff meetings, training, over-service, communication, scheduling, notes about specials. Staff look at these notices every shift.

The Bartender said she has taken the Serving It Right program online. She is familiar with the manual and said she has told the staff there is a copy behind the bar. She did not learn anything about alcohol poisoning from the Serving It Right program. She has taken no training that talks about fatal levels of intoxication, nor any training about when it is appropriate to call an ambulance.

On the night of August 27, 2011, when asked if she considered calling an ambulance, the Bartender said she did not because she saw and heard Server 3 ask if Female Patron D was okay and her friends seemed not to be concerned about it.

Asked what she has learned from this incident, the Bartender said she never wants anything like this to happen again. She personally doesn't serve as much alcohol anymore and will cut people off more easily. She said others at the Pub have adopted this approach.

Since the incident, she has investigated further about alcohol issues, reading articles and books on addiction and looking online about other cases. When asked if she would do anything different today, the Bartender replied that she would call an ambulance. When asked how this has affected her, she said it was devastating.

She lives alone, supports herself and has no savings. The Bartender said if the Pub closed for a month, she would not be able to live. She said many of the staff depend on the tips, not the wages, to ensure they have sufficient income to live. She said some of the other staff have dependent children and many do not have other family support.

Cross-examination

On cross-examination, the Bartender agreed that the visual demonstration of the glasses on the table (shots, wine and pitchers) represented the amount of liquor served to table 36.

She recalled Server 3 bringing concerns about table 36 to her attention about 6:30 p.m. She said that the table was cut off about that time because the gentleman was being rude, not cut off for being intoxicated.

The Bartender agreed that when she started working at the Pub, she was not provided with any written in-house policy on intoxication, nor was there any in-house written policy with respect to how to cut off patrons, nor how to identify intoxicated patrons, nor has the Licensee conducted any written tests with respect to intoxication.

She did not write about this incident in the incident log book. The Licensee reviewed the incident log book with her. It described the situation on August 27, 2011. Management did not review the incident log book at a general staff meeting. She is not aware of how many times the log book may mention police being called, but agreed such incidents would be recorded.

She said she attends the mandatory staff meetings and that they sign attendance sheets. Asked when was the last time she was provided with a handout prior to a staff meeting, she said maybe about ten months to a year ago. The Bartender said the Pub does not have a written training manual for staff.

She agreed the Licensee has not reviewed the Guide with her at any time.

Asked if it is usual for servers to be provided shots by customers, the Bartender said it was. Servers will have the shots when they complete their shifts if they want them. When asked what items were not consumed by the patrons at table 36 (Exhibit 1, tab 17 (ii) shows the summary of total drinks billed), she replied that the few shots for Server 3 were the crispy crunches and that there were a few drinks returned. She believed Server 3 removed about three drinks from the table.

The Bartender agreed it was not usual to have patrons putting their head on table. She had no conversation with the table when she observed this. She was standing a few feet away when she heard Female Patron D slurring her words when they were leaving.

The Supervising Director of the Pub

R. Thomas Burley (the "Supervising Director") appeared as the licensee's representative at the hearing and testified on behalf of the Licensee. He is a chartered Accountant and General Manager and CEO of another company. He is also the supervising director of the Gorge Pointe Pub. He gave some of his professional background and his volunteer experience in the community. In 2012, he received Canada's Caring Canadian Award for Community Service.

The Supervising Director explained the ownership and management arrangements at the Pub. In 2006, he entered into an arrangement to buy the Pub with five other partners. Two of the partners were to be the operators of the Pub with the rest as silent partners. One of these operating partners left the Pub in 2011 and the other took over.

He said it was a tough time in the industry in 2011. The economy was not doing well, the HST came in, and new regulations regarding the .05 driving limits came in. The Pub felt the impact. The owners had to make financial contributions to help cover expenses. Eventually the operating partner was asked to leave and the remaining partners hired a manager who had worked at the Pub at a previous time.

As the Supervising Director's other company has an office upstairs, in the fall of 2011 he agreed to take on the supervisory role on behalf of the owners and directors. He became involved in providing direction to managers, including the chef.

They run essentially two businesses: the Pub and the beer and wine store, which are quite different. The Supervising Director said they decided that they needed to hire another manager just for the Pub, and let the first manager concentrate on the beer and wine store management. They initiated the search for a new manager in the fall of 2011.

The Supervising Director felt that the management arrangement at the time of the incident on August 27, 2011 contributed to what happened. He felt that one manager handling both the beer and wine store and the Pub was stretched too thin. They hired a manager just for the Pub in April 2012, who left just a few months ago.

When the Pub manager left, the owners assessed the situation and concluded that there were some good people working in the Pub, and instead of parachuting someone in to manage, they restructured things in the Pub, promoted a few people and divided up management duties in a different way. They created two new positions and made promotions, such as the head bartender and head server (the Bartender).

The Supervising Director testified that the head server has a supervisory role. She is responsible for supervising the entire serving staff, for training new staff, for approving staff changes from bussers to servers, for ongoing staff training, and for ensuring compliance with the Serving It Right manual. Senior management has told her that staff must understand the Serving It Right manual and must know when to cut off people and how to prevent over-service etc. The head bartender is responsible for the bar and for making sure it is stocked and she is responsible for supervising the other bartenders. No new bartenders have started since they created this position.

The Supervising Director said that he personally has emphasized that failure to comply with these directions will result in termination. They never want a repeat of the events of August 27, 2011. He stated that they do not serve people to the point of intoxication and that they will cut them off earlier than other establishments in the city might do.

The Supervising Director was asked about the basis of the Pub's policies with respect to alcohol service. He stated it is a combination of the Serving It Right manual and, for management, the Guide. They are also trying to ensure that there is always a management staff person in the house. Besides the Bartender, there is another head server and head bartender and the two always work different shifts. In their absence,

the chef has management authority, and quite often the beer and wine store manager will be on hand as needed.

All staff are required to have the Serving It Right certificate. When asked about the fact that Server 3 did not have one on August 27, 2011, he stated that he was not aware of that fact until the week of the hearing.

The Supervising Director described the Pub as a neighbourhood pub, which may attract customers not in the immediate area. It is not a destination bar. People who are driving by the Pub may stop for a bite to eat in a fairly relaxed and casual setting. Their food to liquor ratio is always 50/50.

With respect to problems that the Pub has had with patrons or service issues, he stated they have been few and far between. The Supervising Director testified that there have been incidents where people have been escorted out, especially in the early years because they were wanting to scuffle. He said they have not had an incident of that sort for years. He said staff regularly cut people off without incident.

The Supervising Director said the circumstances on August 27, 2011 were so far out of anything they had ever experienced that it shook all of them. When asked how the events of August 27, 2011 have affected him, he stated there was both a business side and a personal side. He has been quite involved in community activities and cares about his community, so his association with someone who died as a result of his business has been devastating. From a business point of view, he has a role in the management. He said they are not going to be the kind of establishment where something like this could ever happen again.

Asked if he has spoken to staff about what occurred, the Supervising Director said they have managers who do this, and he gives directions to these managers who then speak with the staff. He has made it clear to his managers what they must do if they wish to keep their jobs. His directions have been in group or staff meetings.

He has had conversations with some individual staff members, who have come to him to discuss the incident and he has observed changes in the staff attitudes. He said that those who have chosen to stay with the Pub do not want to over-serve. As he works upstairs, he will often go down to the Pub at the end of the day. The Supervising Director has seen servers handing people their bill after asking them to leave. He says he does not observe signs of intoxication in these people, but staff say they have observed them.

There is communication now between the servers when they transfer tables on shift changes. The Supervising Director said that this lack of communication was the biggest failing on August 27, 2011. Server 3 felt that if she had known that they had been in the bar since 2:00 p.m. or so, she never would have let their consumption get to the level that it did. People have asked him if they are worried about not selling as much, and his response is better not to sell as much than to have this happen again.

The Supervising Director attends the majority of staff meetings. They have reviewed the need for improved communication, the need for people to be aware of the signs of intoxication. He agreed they don't have a lot of written policies. He stated they rely a lot on the Serving It Right program to provide training for their staff and said that reliance may not be justified because of some things it does not address. In his experience, with this generation of people, he said they are not readers of manuals and benefit more from face to face communication. He agreed this was not happening often enough prior to August 27, 2011.

The Pub has a few bulletin boards—one for kitchen and one for bar. These are used for posting all kinds of messages, whether it is the need for more toilet paper or reminders about service. The only time the staff are together at the same time is at the staff meetings. The boards help with communication between staff meetings.

In establishing the parameters for the new management structure with head servers and head bartenders and the involvement of the chef, management has agreed there should be a lot more one on one assessment and feedback to staff. The Supervising Director said they are going through a process now where the heads are meeting with individual staff about their job duties. Liquor service is one of the key topics that they are addressing with the staff.

He said, since the August 27, 2011 incident, staff have asked a lot of questions about what they should be doing, for example, when should they be calling 911. Some staff commented that no one had ever told them to do more than ensuring patrons get to a safe place to sober up.

The Supervising Director thinks there is a failing in terms of the branch and what they expect of Licensees, with respect to going beyond the guidelines in the Serving It Right program. Perhaps managers should be conveying more about calling 911, but he said no one had ever heard of this type of incident. Perhaps they should have called an ambulance to save this person's life, but this is not what is emphasized in Serving It Right manual, nor is it emphasized in the majority of infractions that they hear about.

The concerns they have been told to focus on are watching for signs of intoxication and then refusing service, whether the establishment is making efforts to get an intoxicated patron home safely and the establishment's responsibility if a person drives away and gets in an accident. The Supervising Director said, if the manual says to get them somewhere safe, if friends say they are okay and will take care of them, they don't know what else they should be doing. He said he does not have a good answer for staff on this.

When asked about the impact of a month long suspension, The Supervising Director said the servers will be affected most as they may not be able to pay their rent or feed their kids. He said they cannot get employment insurance for this time as they do not earn insurance on their tips. There are about 40 staff who work in the Pub and beer and wine store.

When asked how this incident has changed the Pub, the Supervising Director said it has changed the behaviour of staff and their performance in their jobs. There are a number of staff who have been preoccupied with what happened and cannot stop talking about it and the possible final consequences. He said the business is still hurting somewhat financially but they continue to provide good service and customers continue to enjoy coming there, and their staff like working there.

Cross-examination

On cross-examination, the Supervising Director agreed he was not in the Pub on August 27, 2011. He learned about the incident on the Monday following when he returned to work and spoke with the then manager of the Pub. He didn't learn the details until sometime later.

The Supervising Director said he learned the police were making inquiries, as they were asked to provide certain information because one of their patrons had died on the weekend. He did not really know whether there was even a connection between the death and the Pub. He did not understand, until sometime later, that the branch was alleging that the Pub played a significant role in the woman's death.

The Supervising Director confirmed he does not have a Serving It Right certificate.

The Supervising Director was aware that there was a directive to staff asking them to provide an incident report. He did not review the incident log, just discussed it with the manager. He agreed there are no minutes of staff meetings. If the list of things for discussion is lengthy, they will write it down and distribute it. Management may just make a list themselves of the things they intend to discuss.

He doubted that management staff would have reviewed the Guide with the employees at the Pub.

SUBMISSIONS – THE BRANCH

The branch noted that the Licensee had admitted that the contravention occurred and is disputing the penalty only at this hearing. As the Licensee has admitted to the contravention of section 43(2)(a) of the Act, there is no need to address the alternative contravention of section 43(2)(b) in the NOEA.

The branch noted the following facts:

1. Female Patron D was intoxicated on August 27, 2011, after spending almost four hours drinking in the Pub and as a result of the liquor she consumed in the Pub.
2. The coroner's report lists the immediate cause of death of Female Patron D as "lethal ethyl alcohol poisoning."
3. The toxicology report showed no drugs were involved in her death.

The branch submitted that the recommended penalty of 30 days is appropriate, necessary and warranted to bring the Licensee into compliance with the terms and conditions of its Licence.

SUBMISSIONS – THE LICENSEE

The Licensee, as noted, admitted the contravention of section 43(2)(a) and did not present a defence of due diligence.

The Licensee disputed the penalty of a 30 day suspension and argued that any penalty imposed against the Licensee should fall within the maximum range set out for a first contravention. The Licensee said that the Pub has been an exemplary establishment for well over a decade.

The Licensee submitted that the circumstances of this incident are unusual and include the sudden onset of intoxication of the female patron and her subsequent death, as well as the failure of the Serving It Right program to provide adequate training in the recognition of alcohol poisoning symptoms or the procedures that should be followed in responding to such symptoms. The Licensee therefore argued that it is not in the public interest to exceed the maximum penalty for this first contravention.

The Licensee reviewed the facts as set out in the NOEA and said that the evidence at the hearing demonstrates that some of these facts are inaccurate. Therefore, the Licensee stated, as the basis for the 30 day recommended penalty is not supported by the evidence at the hearing, that I as the General Manager's delegate, should consider a much lesser penalty that is reasonable and appropriate to the circumstances of this contravention.

The Licensee submitted that the following facts have been established by the evidence presented at the hearing:

1. When the servers noticed the sudden onset of Female Patron D's intoxication they stopped the service of alcohol.
2. The other three patrons with Female Patron D did not exhibit any signs of intoxication.
3. The servers attempted to remove Female Patron D from the red-lined area.
4. They called a cab to ensure she returned home safely. They watched while the patrons entered the cab.
5. They further refused the sale of alcohol to another member of the group who went into the beer and wine store after being asked to leave the Pub.

6. The servers complied with the criteria required of Serving It Right's primary goal which is the prevention of an intoxicated patron injuring others or themselves, by driving while intoxicated or fighting.
7. The servers followed the directions that an intoxicated person not remain in the Pub. The subsequent quick removal may have prevented the servers from being able to see the progression of the female patron's level of intoxication.
8. The conclusions of the toxicologist that Female Patron D was showing signs of intoxication much earlier in the evening is not supported by the eyewitnesses or the videotapes.
9. The assumptions made by the toxicologist in forming his opinion are not supported by the evidence: calculation of the amount of liquor consumed by Female Patron D, consumption of the nachos, the state of consciousness of Female Patron D when leaving the Pub, the weight of Female Patron D.

The Licensee submitted that during the majority of the four hours that the four patrons were in the Pub, Female Patron D was drinking within the established guidelines as set by Serving It Right. Her system became overwhelmed suddenly by the consumption of the vodka shooters and jumped to the lethal levels that eventually killed her. The Licensee further submitted that it is possible that Female Patron D had a much lower ability to quickly metabolize a large influx of alcohol, as is evidenced by the statements about how she had quickly become intoxicated in past incidents when she drank too much.

Since the contravention on August 27, 2011, the Licensee has implemented changes to assist in preventing any further such incidents, including: making communication amongst the servers a high priority, ensuring bills are printed off when tables are transferred, instructing staff that failure to deny service to intoxicated patrons can lead to termination.

While the Licensee accepted that over-service occurred on August 27, 2011, the Licensee submitted that a 30 day suspension is entirely outside the ambit of what is appropriate and that the recommended penalty is based on the resulting very tragic death of Female Patron D rather than on the actual facts of the over-service.

The Licensee stated there was absolutely no collective or wilful disregard for the safety of its patrons. In fact, the staff did what they had been trained to do and followed the instructions in the Serving It Right manual:

- They called a cab
- They refused service in the beer and wine store
- They cleared the table
- This all happened within minutes of the sudden signs of intoxication of Female Patron D

The Licensee's counsel cited a number of branch enforcement hearing decisions dealing with intoxication where, he stated, the facts of the signs of intoxication and the staff's failure to react to these signs were much more egregious than the facts here. He said, in the majority of the cases dealing with a first contravention, the penalty is within the range set out in Schedule 4. He concluded his review of branch decisions with the submission that these show the great disparity in the proposed suspension for the Pub.

He agreed that the death of the female patron was very tragic and management and all staff wish they could have foreseen and prevented her death.

The Licensee's counsel concluded his submission with the admission that Female Patron D was over-served in the Pub. He submitted however that the evidence here shows that the signs of intoxication were sudden, and when staff observed them, they acted. He argued for a lesser penalty on the basis that:

- The mere fact of what occurred is clear motivation to ensure compliance
- It is improper to base the imposition of a lengthy penalty on the death of Female Patron D
- This is not a forum to punish, rather to encourage and obtain compliance
- The penalty must be reasonable and commensurate to the errors which occurred
- The Pub is a well-run establishment with a long history and no prior infractions
- Management changes have been implemented along with increased training and awareness of staff
- There is increased communication among staff and management has made it clear that over-service can and will result in termination of employment
- The actions of many other licensees have been much worse, with lighter penalties imposed

REASONS AND DECISION

Contravention and Due Diligence

The Licensee admits that it permitted a person to become intoxicated on August 27, 2011.

The Licensee is entitled to a defence if it can be shown that it was duly diligent in taking reasonable steps to prevent the contravention from occurring. The Licensee must not only establish procedures to identify and deal with problems, it must ensure that those procedures are consistently acted upon and problems are dealt with.

The Licensee has admitted the contravention and is not making a defence of due diligence. On the facts of this case, I find that the Licensee would fail in making a due diligence defence. The Pub had no written policies, no records of staff meetings, no incident log provided to the branch, and no communication procedures established when tables were transferred to other servers. None of the staff who testified were familiar with the Guide. In addition, the main server involved in this incident was young and inexperienced, with little training on dealing with over-service, did not have her Serving It Right certificate, and had minimal supervision with respect to the service to table 36 on August 27, 2011.

I therefore find that the Licensee contravened section 43(2)(a) of the Act on August 27, 2011 and that the Licensee has not established a defence of due diligence.

Findings of Fact

In order to suspend a liquor licence for a period longer than the range set out in the prescribed schedule of suspensions, I must be satisfied that it is in the public interest to do so. In making this determination, I must consider the particular circumstances of this contravention. Thus, the Licensee's admission to the contravention does not obviate the need to make findings of fact about the particular circumstances of the contravention, as these findings will affect my decision on what penalty, if any, is appropriate and reasonable.

As the delegate of the General Manager, I am required to assess the evidence at the hearing, to determine to the best of my ability what occurred, and then to draw conclusions about those facts. In drawing conclusions from the evidence at the hearing, I have given some weight to the transcript evidence of the three patrons, when there is no other evidence available (when the patrons were in the cab or in the apartment), or when two or three of the patrons recalled the same fact. I have also referred to their statements when they substantiate the video evidence or the statements of the staff witnesses. Their failure to recollect certain actions raises questions about the reliability

of the memories of all three patrons. In addition, as the three patrons were not available for cross-examination, I have given their individual statements less weight.

I make the following findings of fact regarding the events of August 27/28, 2011:

1. Four patrons entered the Pub at 14:40 on August 27, 2011. (Exhibit 2, videotape)
2. Female Patron D had consumed no alcohol prior to coming to the Pub. (Exhibit 1, tab 15 (a),(b) and (d), transcript evidence of the three patrons)
3. The four patrons sat at table 36. (Exhibit 2, videotape, testimony of servers and transcript evidence of patrons)
4. From the time the four patrons entered the Pub at 14:40 and exited at 18:54, the servers in the Pub served table 36 a total of five (5) jugs of beer, six (6) glasses of white wine, nineteen (19) shots of vodka, three (3) vodka and cokes, and a plate of nachos. (Exhibit 1, tab 11, checks reports for table 36)
5. Server 1 initially served table 36 and finished her shift at 16:30. Table 36 paid the bill up to that time. The bill showed payment for 3 jugs of beer and 3 glasses of wine, served over the roughly two hour period, between 14:40 and 16:30. (Exhibit 1, tab 11, checks report showing bill of $69.42 paid before 16:21)
6. The next two servers did not know what had been served to table 36 because the bill up to 16:21 had been paid and Server 1 did not tell them when transferring the table. (testimony of Servers 2 and 3, Exhibit 1, tab 15(e), transcript evidence of Server 1)
7. Server 2 took over the table and brought a fourth jug of beer to table 36 and then, within a half an hour at 17:00, she transferred the table to Server 3. (testimony of Servers 2 and 3 Exhibit 1, tab 15(e), transcript evidence of Server 1)
8. From 16:30 to 18:20, Server 2 and Server 3 provided table 36 with two jugs of beer, three glasses of wine, nineteen shots of vodka, three vodka and cokes, and a plate of nachos. (Exhibit 1, tab 11, checks report showing two bills, one for $99.14 and the other for $102.00). The nachos were served at 17:20, and Female Patron D consumed most of them. (Exhibit 2, videotape, Exhibit 1, tab 15(b), transcript evidence of Female Patron B)

9. In addition to four or five vodka shooters, Female Patron D drank only wine and probably did not consume all six glasses of wine. (testimony of Server 3, Exhibit 1, tab 15(b), transcript evidence of Female Patron B)
10. At 18:25, Female Patron D started showing very obvious signs of impairment. At 18:30, Female Patron B moved to sit beside Female Patron D when she was having difficulty sitting up. (Exhibit 2, videotape, testimony of Liquor Inspector from observations of videotape, Exhibit 1, tab 15(b), transcript evidence of Female Patron B, testimony of Server 3**)**
11. None of the other three patrons showed any signs of intoxication during their time in the Pub. (testimony of Liquor Inspector from observations of videotape, my observations of videotape, testimony of servers and bartender)
12. Prior to 18:25, the patrons at table 36 appeared to be having a good time, talking and laughing and interacting often with Server 3. They bought Server 3 two "crispy crunches" which were added to their bill but were not consumed. (Exhibit 1, tab 11, checks report, testimony of Server 3 and the Bartender)
13. From 18:30 on, Female Patron D was having great difficulty sitting upright, at times with her head on the table and at times leaning on another patron at the table. (testimony of Server 3, the Bartender, Exhibit 1, tab 15(b) transcript evidence of Female Patron B, Exhibit 2, videotape)
14. Server 3 informed the table that they would have to leave and then brought the bills to the table, which were paid by Female Patron B and Male Patron C. Female Patron B's visa receipt for her bill had a time stamp of 18:43. (Exhibit 3) Male Patron C paid the first bill some 8 to 10 minutes earlier. (testimony of Server 3)
15. Server 3 called a cab sometime between 18:30 and 18:43. (testimony of Server 3 and the Bartender)
16. Server 3 cleared the table between 18:30 and 18:45. (testimony of Server 3)
17. At about 18:50, Server 3 requested the patrons at table 36 to wait outside the red-lined area. (testimony of Server 3, Exhibit 1, tab 15(b) transcript evidence of Female Patron B, Exhibit 2, videotape)

18. The patrons refused to leave the table until the cab arrived and then began to leave the Pub at 18:52. Server 3 and Female Patron B helped Female Patron D to stand at the table and then Male Patron A lifted her up and carried her from the Pub. (testimony of Server 3 and the Bartender, Exhibit 2, videotape)
19. Female Patron D was seated in the cab between Female Patron B and Male Patron C. (testimony of Server 3, Exhibit 1, tab 15(b) and (d), transcript evidence of Female Patron B and Male Patron C)
20. Male Patron A entered the beer and wine store where he was refused service as a result of the Bartender indicating the cut-off sign to the Store Employee. (testimony of the Bartender and the Store Employee)
21. On the cab ride home, Female Patron D vomited a little bit of liquid. (transcript evidence of Male Patron A and Female Patron B, testimony of Police Officer A who interviewed Female Patron B on the night of the incident)
22. Male Patron A carried Female Patron D to the apartment where she was laid on her bed, face down. (Exhibit 1, tab 15 (a), (b) and (d), transcript evidence of three patrons)
23. The coroner's report concluded Female Patron D died at about 22:00 on August 27, 2011 and that the immediate cause of death was "lethal ethyl alcohol toxicity." (Exhibit 1, tab 21, coroner's report)
24. Female Patron D's Blood Alcohol Concentration (BAC) was .300 mg% at the time of death. (Exhibit 1, tab 22, Provincial Toxicology Centre report)

Based on the findings of fact above, I conclude that Female Patron D was over-served in the Pub on August 27, 2011. The alcohol she consumed in the Pub resulted in the lethal ethyl alcohol poisoning and her subsequent death.

In addition to the above findings, there are three issues that require findings of fact in order for me to properly assess the particular circumstances of this contravention for the purpose of determining whether the 30 days recommendation in the NOEA is a reasonable and appropriate penalty. In addition, if I determine any penalty above the maximum in the Schedule is appropriate, I must be satisfied that it is in the public

interest to do so and thus take into account any particular circumstances that justify a penalty greater than the maximum.

The first two issues arise from the comments in the NOEA about the wilful disregard displayed by the Licensee for the safety of its patrons, and the quote from the coroner's report about the level of consciousness of Female Patron D. The third issue arises from the evidence at the hearing with respect to the Licensee's policies and staff training. The three issues are:

1. Was there gross over-service in the Pub combined with a "collective and willful disregard" for the safety of its patrons?
2. Was Female Patron D unconscious at the time of leaving the Pub and if so, what was the responsibility of the Pub staff at this point?
3. Did the absence of written house policies and/or specific training on over-service contribute to the contravention?

Was there gross over-service in the Pub combined with a "collective and wilful disregard" for the safety of its patrons?

One of the reasons given by the Liquor Inspector for recommending a 30 day suspension was "the circumstances of gross over-service combined with what appears to be a collective and wilful disregard for its primary responsibility, the safety of its patrons." In addition, the Liquor Inspector concluded in the NOEA that "the licensee failed to abide by its legal obligations and contrary to any rudimentary common sense continued to serve liquor beyond the amount any reasonable person might consider rational."

As the hearing delegate, I have had the benefit of hearing the testimony of the Pub employees, the only witnesses at the hearing who were present at the time of the contravention. I have also reviewed the transcript evidence of the three patrons and, as previously noted, I have referred to that evidence as support for the employees' observations. As well, I heard evidence from Police Officer A, who interviewed the three

patrons on the night of the incident. I have given more weight to Female Patron B's statements in the transcript evidence when consistent with statements given to the police officer on the night of August 27/28, 2011. I have made my own observations from the videotape evidence and have found them to be consistent with the observations of the Liquor Inspector, as recorded at tab 17 of Exhibit 1.

I find that there was gross over-service on the afternoon/evening of August 27, 2011. This over-service resulted in the severe intoxication of Female Patron D. Female Patron D was carried from the Pub when she was unable to walk on her own. As described in the Toxicology Consultant's report, she was in the 5th state of alcohol influence—stupor. The state of stupor (BAC 270 to 400 mg%) includes inability to stand or walk as one of the signs. This fact alone supports my finding that there was gross over-service.

I find that only one of the four patrons was showing obvious signs of intoxication. The evidence of the absence of signs of intoxication of the other three patrons was uncontroverted. None of them showed any visible signs either on the videotape or as observed by the servers. Nevertheless, as noted in the Serving It Right manual, the absence of signs of intoxication does not relieve the Pub staff from the responsibility to monitor the service to its patrons.

As is obvious from the appearance and actions of the other three patrons when leaving the Pub, they had a much higher tolerance for alcohol than did Female Patron D. As the Toxicology Consultant admitted, and as the Physician opined, there are people who continue to function with a much higher BAC level than Female Patron D had. As suggested by the husband in his interview with the police officer, Female Patron D had a low tolerance for alcohol. Female Patron B, who had been a bar manager, could not believe that Female Patron D had died of alcohol poisoning, as she had consumed the least of the four of them.

I find that Female Patron D consumed the greatest amount of alcohol during the latter part of her time in the Pub. During the first two hours in the Pub, Server 1 provided table 36 with three jugs of beer and three glasses of wine. During the latter two hour period, the four patrons were served two jugs of beer, three glasses of wine, nineteen shots of vodka, and three vodka and cokes. The Pub staff served almost double the amount of alcohol in the latter two hour period than in the first two hour period. I accept the evidence of Server 3 and the Bartender that a few drinks on the bills were for the consumption of the server. I find that these were the two crispy crunches. Although Server 3 maintained she only served four rounds of shooters to table 36, for a total of sixteen shooters, the bill shows nineteen vodka shooters. I therefore find that the four patrons consumed nineteen vodka shooters and the three vodka/cokes, all of which were consumed between 17:00 and 18:20.

Setting aside the server's lack of awareness of what was served before her shift, the amount that Server 3 served in the period of time between 17:00 and 18:20 was particularly excessive and amounted to irresponsible service. During this period, Female Patron D was served 3 glasses of wine and 4 or 5 shots of vodka. (Exhibit 1, tab 11, checks reports, testimony of Server 3, Exhibit 1, tab 15(b), transcript evidence of Female Patron B)

I find that the serving staff did not monitor the consumption of alcohol at table 36, particularly in the last hour and a half. The Bartender was aware of what drinks she was pouring for table 36 but said nothing to the inexperienced server. I find that the young server here, with limited experience as a server and without the rudimentary basic training provided by Serving It Right, was not adequately supervised as she continued to serve table 36.

Neither Server 3 nor the Bartender was aware of the difference in alcohol tolerance in older people or between men and women. Female Patron D was clearly at a greater risk of alcohol poisoning because of her age, gender, and possibly her metabolism and general intolerance to alcohol. These are all factors that are mentioned in the Serving It Right manual, factors that should be emphasized by licensees in their written house policies on avoiding over-service.

I find that the service did not continue to table 36 after the first obvious signs of intoxication. My observations and the observations of others of the videotape evidence support the statements of the servers and the patrons that the first signs of intoxication were severe and sudden. I find that, once the servers observed Female Patron D's obvious signs of impairment, they did not serve any more alcohol to table 36.

I have watched the videotape and have reviewed the observations of the video by the Liquor Inspector (Exhibit 1, tab 17). I agree with the Licensee's counsel that I am able to make my own observations from watching the videotape. However, I have also compared my observations to those of the Liquor Inspector, as she is someone who is well qualified to note the signs of intoxication from her years of experience and training as a liquor inspector. The Liquor Inspector observed "the beginning of the obvious signs of impairment" at 18:25. I observed signs of severe intoxication, with her head on the table and then falling back again, at 18:25.

I observed Female Patron D's actions at earlier times in the video. There was some behaviour at an earlier time which could have suggested she was becoming drunk, but certainly not conclusive. I observed the movement and gestures of the patrons at the neighbouring table, which suggested animated and lively conversations with arm movements, nothing very different from the early observations of Female Patron D. There was no suggestion that there was any over-service to the neighbouring table.

The Liquor Inspector assumed there were signs obvious to the server at an earlier time than 18:25, such as slurring of speech, etc. Given how severe the signs of intoxication were around 18:30, it is surprising that Female Patron D was not showing some earlier signs and showing a gradually increasing level of intoxication. However, the evidence at the hearing about the sudden onset of intoxication signs came from a number of sources: the transcript evidence of the three patrons, the testimony of Server 3 and the Bartender, as well as Police Officer E's observations of the videotape. All were emphatic about the very sudden shift in behaviour of Female Patron D. Server 3 referred to the sudden onset of the intoxication, both in her testimony at the hearing and in her February 2012 interview with Police Officer C, who found her forthright and credible. Having heard the testimony of Server 3, I find that she was interacting regularly with table 36 and, in doing so, had the opportunity to observe earlier signs of intoxication in Female Patron D. I accept the statements of Server 3 and the Bartender that they observed no signs of intoxication in Female Patron D prior to 18:25.

The Liquor Inspector's observations of the videotape refer to Female Patron D at 18:17 as "upright, looking around." At 18:18, Server 3 is at the table with a serving tray, which may have been the service of the last round of shooters. At 18:25 on the video, Female Patron D is beginning to show some obvious signs of impairment by her awkward movements, leaning on the table and then leaning back with her legs open and her skirt up. Female Patron B moves to sit beside her at 18:30, when she started showing these signs of intoxication.

There is no evidence to suggest that alcohol was served to the table after 18:18, which was before any obvious signs of impairment can be seen on the video. There is evidence to show that one of the bills was paid at 18:43 (Exhibit 3, visa receipt) and evidence that the other bill was paid about 10 minutes before this one, and thus, I find that the presence of the server at the table after 18:25 was to inform the party that she would no longer be serving them, offering to bring the bills, offering to call a cab, etc.

I note that the Liquor Inspector agreed on cross-examination that, when she observed the videotape, she thought more liquor was being served when she saw a server at the table at 18:18, but that she could not actually see the service nor did she know exactly what was being cleared from the table. She merely observed the server coming to the table. I made these same observations. The Liquor Inspector agreed that the many interactions of the server with the table after 18:18 could have been requests to leave, bringing the bills, asking about calling a cab. The Liquor Inspector agreed she relied on the coroner's report to draw her conclusions about the recommended penalty.

I wish to comment here on the inconsistency in Server 3's interview evidence with Police Officer C and her testimony at the hearing. In her interview with the police officer, on February 14, 2012, she stated that she cut off the table at the first signs of intoxication. In the hearing, she testified that she cut off the table because of the rudeness of Male Patron A. In her interview statement, she told the police officer that she noticed Female Patron D beginning to shows some signs of intoxication and then told the Bartender that she was cutting off the table. She also told the police officer that Male Patron A became annoyed over the bill. At the hearing, both Server 3 and the Bartender testified that table 36 was initially cut off because Male Patron A was being rude to the server. The Bartender testified that she instructed Server 3 to serve last shots and then cut them off if he was being rude to her. As Server 3 was not challenged on this inconsistency in cross-examination, I am relying on the best evidence before me which is that of the two staff who testified at the hearing. Regardless as to whether or not the patrons were initially cut off because of the obvious signs of intoxication of Female Patron D or whether the table was initially cut off because of Male Patron A's rudeness, I have found that the first obvious signs of impairment occurred after the last round of shooters was served.

I have found that staff did not continue to serve once they observed the obvious signs of intoxication in Female Patron D. I find that staff then took the necessary actions to remove the patrons.

Given the steps taken by staff to remove the patrons after observing Female Patron D's level of intoxication, I do not characterize the actions of the staff at this point as demonstrating a collective and wilful disregard for the safety of the patrons. However, I find that the failure of the Licensee in its responsibility to ensure its staff are well trained and cognizant of responsible service guidelines demonstrates a disregard for its staff as well as for the safety of its patrons.

Was Female Patron D unconscious at the time of leaving the Pub and if so, what was the responsibility of the Pub staff at this point?

The coroner concluded in his report that Female Patron D was unconscious when she was being carried out of the Pub. The Liquor Inspector quoted this conclusion in the NOEA. The Toxicology Consultant relied on the coroner's statements, as he did not view the videotape prior to writing his report. The Toxicology Consultant concluded in his report "that she would have shown signs of intoxication far before she passed out and had to be carried out of the Pub." He thus relied on the belief that she was unconscious at that point to support his conclusion that she should not have been served any more alcohol far earlier in the evening (Exhibit 1, tab 22, Toxicology Consultant's report).

The Toxicology Consultant estimated Female Patron D's BAC to be 330 to 360 mg% at the time of leaving the Pub. The Toxicology Consultant agreed that if she ate a plate of nachos before drinking the shooters, this might have slightly slowed down the rate of absorption of alcohol into her blood. He assumed that Female Patron D eliminated alcohol at the average rate of between 10 and 20 mg% per hour. It is possible that she did not eliminate alcohol at this rate. I find that, with a BAC at the time of death of 300 mg%, it is possible that Female Patron D's BAC was not as high as 330 to 360 mg% when leaving the Pub. Thus, the conclusions of the Toxicology Consultant as to her level of consciousness and increasing signs of intoxication may not be supported by the evidence at the hearing of Female Patron D's drinking pattern and food consumption.

He noted in his report that his conclusions on her BAC were only valid if all the alcohol were absorbed into her blood.

Female Patron D's rapid consumption of the shooters may have caused the rapid rise in her BAC and this rise in her BAC may have occurred half an hour to an hour after the consumption of alcohol, according to the Toxicology Consultant. Therefore, her highest BAC could have been after she left the Pub. I find that the rapid consumption of vodka shooters in a short period of time raised her BAC level suddenly and is consistent with the evidence about the sudden onset of intoxication in Female Patron D. I base this conclusion on the expert opinion of the Toxicology Consultant who agreed that, if they rapidly drank shooters at the end of the drinking session, the BAC would rise rapidly.

I find that Female Patron D was barely conscious when the patrons left the Pub (my observations of the videotape, the testimony of Server 3 and the Bartender, Exhibit 1, tab 15(b) and (d), transcript evidence of two patrons). Although she was unable to walk and was carried from the Pub, it is difficult to determine from the videotape whether she had reached a state of unconsciousness at that point. Server 3 testified that she was conscious and the Bartender heard her mumbling when the patrons were leaving the Pub, as did Female Patron B. Two of the three patrons, in their interviews with the police, stated that she vomited in the cab and was conscious. Female Patron B also stated this on the night of the incident, when interviewed by the attending police officer. In his statement to the police officer, Male Patron C said she was mumbling when they carried his wife to the apartment.

The Liquor Inspector suggested in the NOEA that, given what she thought was the unconscious state of Female Patron D at the time of leaving the Pub, staff should have called for an ambulance instead of a cab. In hindsight, I find that everyone involved in this incident believed they should have called 911, which may have avoided the tragic death of Female Patron D.

I find that when the patrons were asked to leave, Female Patron D was still conscious, although unable to walk once the patrons got up to leave the Pub. Server 3 asked the other three patrons if Female Patron D was okay. Her friends and husband, who showed no overt signs of intoxication, said she just needed to get home and she would be fine. The Bartender emphasized that they always ensure their possibly intoxicated patrons get home safely, and that they do not get into a vehicle.

I find that, once Female Patron D started showing signs of severe intoxication, the Pub staff asked the party to leave, as they are required to do by the Act, and proceeded to provide them with their bills and make arrangements for them to get home safely. They followed the Serving It Right manual guidelines for removing intoxicated patrons. The manual focuses on ensuring patrons get home safely if they are intoxicated and ensuring they are removed from the Pub (page 33). What is missing from the Serving It Right manual is advice on lethal alcohol poisoning and when Pub staff should consider calling an ambulance.

I find further that, in the situation here where there were four patrons, three of whom appeared to show no overt signs of intoxication, who were assuring staff that the severely intoxicated patron would be fine, the responsibility of the staff was to ask them to leave the premises and to ensure they had a safe ride home. In the face of the response from the patrons about Female Patron D, I am unable to conclude that the staff should have called 911 and literally detain the patrons until an ambulance arrived to assess the situation.

Did the absence of written house policies and/or specific training on over-service contribute to the contravention?

The Serving It Right manual strongly recommends to licensees that they develop written house policies, working with staff to address issues such as the service to minors and intoxication. The manual (page 40) notes that the promotion of responsible service depends to a large extent on an establishment's written policies. The manual sets out

in some detail guidelines for developing house policies and for implementing house policies with staff (page 42). A simple policy with respect to the amount of drinks to be served to a table within a certain time period would probably have prevented the over-service here.

I find that the lack of staff training led to the excessive service in this case. Apart from statements about some bussers observing servers, the Licensee presented no evidence about a training program in place at the time of the contravention. The Serving It Right manual provides some good pointers on how to assess patrons before they become intoxicated, which includes monitoring the number of drinks served, but also watching for less overt signs of intoxication. The manual identifies that different people (depending on age, gender, body weight and type, food consumption, general tolerance to alcohol) will react differently. The manual notes that women have less body water with which to dilute alcohol (page 15). Further, the manual warns that increasing the number of drinks consumed in a given time period will greatly influence the rate of intoxication (page 15).

The testimony of the servers and the Bartender about their own alcohol consumption at various times and that of their friends, to support their opinion that the consumption here was not abnormal, did not include consideration of the factors mentioned in the Serving It Right manual. For example, the manual states at page 15 that the livers of young people process alcohol more efficiently than older people's livers. In fact, the staff's testimony demonstrates that the Licensee needs to introduce training about intoxication and to test the awareness of its staff about how differing amounts of alcohol can affect different people.

Avoiding over-service is not simply a matter of waiting to observe signs of intoxication and then ensuring the patron gets home safely; it also requires staff to monitor the number of drinks they serve within a set time period. The staff testimony focused heavily on what to do once a patron became intoxicated and signs of intoxication were noticed, but there was very little awareness in their testimony about the importance of monitoring to avoid over-service.

The Serving It Right manual suggests promoting the service of one drink at a time, which was not done here with the service of both shooters and beer and wine to table 36. The manual (page 18) recommends to licensees that they discuss signs of intoxication and notes: “by the time changes in behaviour are obvious, the patron may already be intoxicated. Your objective is to be able to spot the subtle changes in your customers as they drink, so you can identify when they have had enough before they are intoxicated.”

The Serving It Right manual notes that the average person will process about one standard drink per hour and that a person’s rate of intoxication will increase when alcohol is being absorbed at a faster rate than it is being processed, which was the case with Female Patron D. Server 3 referred to the manual recommendation of two drinks per person per hour. She may have been referring to Appendix D which has a table showing body weight, number of drinks served in an hour, and estimates of BAC levels. Appendix D has a table for males and one for females, demonstrating the gender differences in alcohol tolerance. In the present case, Server 3 served considerably more than 2 drinks an hour to table 36 and was not aware of the gender differences.

The failure here was not only the failure of the server and the Bartender to monitor. It was the failure of the Licensee and its management to ensure that its staff had the training required, so that inexperienced staff were not left to deal with the trauma of an event such as this one. I find that the failure of the Licensee to provide specific training about early signs of intoxication, and the absence of any written policies to guide staff on monitoring drinks, led to this contravention.

I turn now to the question of penalty and what is reasonable and appropriate for what occurred on the afternoon and evening of August 27, 2011.

PENALTY

Pursuant to section 20(2) of the Act, having found that the Licensee has contravened the Act, the Regulations and/or the terms and conditions of the Licence, I may do one or more of the following:

- Take no enforcement action
- Impose terms and conditions on the licence or rescind or amend existing terms and conditions
- Impose a monetary penalty on the Licensee
- Suspend all or any part of the licence
- Cancel all or any part of the licence
- Order the Licensee to transfer the licence

I am not bound to order the penalty proposed in the NOEA. However, if I find that either a licence suspension or a monetary penalty is warranted, I am bound to follow the minimums set out in Schedule 4 of the Regulation. I am not bound by the maximums and may impose higher penalties when it is in the public interest to do so.

On the facts of this contravention, I find that a penalty is warranted given the serious nature of this public safety contravention. The Licensee agrees a penalty is warranted but submits that a penalty within the range for a first contravention is more appropriate and reasonable than the recommended penalty of 30 days.

The branch's primary goal in bringing enforcement action and imposing penalties is achieving voluntary compliance. The factors that are considered in determining the appropriate penalty include whether there is a proven compliance history, a past history of warnings by the branch and/or the police, the seriousness of the contravention, the threat to the public safety and the well-being of the community.

There is no record of a proven contravention of the same type for this Licensee at this establishment within the preceding twelve months of this incident. Therefore, I find this to be a first contravention for the purposes of Schedule 4 and calculating a penalty. Item 10 in Schedule 4 provides a range of penalties for a first contravention of this type: a 4 to 7 day licence suspension and/or a $5000 to $7000 penalty.

Based on her understanding of the facts of the incident, the Liquor Inspector has made a recommendation of 30 days suspension in the NOEA. My task is to review all the evidence at the hearing and to determine whether a 30 day penalty is reasonably and appropriately based. As the delegate of the General Manager, I am required to take into account the Licensee's entire compliance history and the particular circumstances giving rise to the enforcement action to be satisfied that it is in the public interest to impose a suspension greater than the maximum in Schedule 4.

Licensee's compliance history

As noted, this is the Licensee's first contravention of section 43(2)(a) of the Act. In addition, the Licensee has no compliance history noted in the NOEA, no record of past enforcement actions, no record of warnings from the police, and no record of compliance meetings. All of the evidence points to this establishment as a problem-free establishment in terms of its compliance with the Act and Regulation. The staff refer to it as "laid back" with regular customers where food is often as important as the liquor. The statements of all the Victoria area police officers with respect to the Pub and its reputation amongst the police and in the community were consistent—this is a well run Pub with no history of problems. Several of the police officers testified that they have been to the Pub (off-duty) on a number of social occasions.

Determination on penalty – public interest

This was a very serious contravention resulting in the death of a patron, and thus a threat to public safety and the well-being of the community.

The Liquor Inspector noted in her testimony how difficult it was for her to come up with a number for the penalty on the facts of this contravention. She stated that this was one of the hardest recommendations she has ever made in her career as a liquor inspector. The Liquor Inspector's reliance on the statements by the coroner certainly led to her conclusions about the employees' wilful disregard for the safety of its patrons, as noted in the NOEA. The coroner's statements were based on his observations of the videotape. I have concluded above that I do not agree with his statement that additional alcoholic drinks continued to be served to the table while Female Patron D displayed increasing signs of severe intoxication.

The Liquor Inspector agreed that the branch's intention in bringing enforcement action and imposing penalties is not to look at the cause of death but to assess the behaviour and actions of the Licensee. She also stated that the tragic death was a factor in her recommendation.

I find that the death was extremely tragic but not a foreseeable consequence of the alcohol consumption at the Pub. I say this because of the absence of signs of intoxication in the other three patrons. Female Patron B, a woman of similar weight and height, consumed more alcohol than Female Patron D and she was not showing signs of intoxication in the Pub.

I note the comments of the Licensee with respect to the absence of anything about lethal alcohol poisoning in the Serving It Right manual. I found only one reference to possible death from alcohol consumption at page 20, which states that a blood alcohol content of .40% means "a person will be in a coma or could die." Given this tragedy, and others that have occurred elsewhere in the past, it would no doubt be useful for the next version of the Serving It Right manual to include something like the Toxicology

Consultant's stages of intoxication, so that licensees and their employees are well aware of the potential of alcohol to be lethal, and to assist them to know when to respond and when to decide to call an ambulance.

I have found that the staff's failure to monitor the consumption at table 36 caused the gross over-service. I have also noted that the responsibility for this over-service does not lie solely with the servers or the Bartender. A young server—with very limited experience as a server, no guidance or training about over-service, no Serving It Right certificate, and very limited supervision by the person in charge (the Bartender)—has been devastated by what happened to one of the Pub's patrons on August 27, 2011.

The Serving It Right manual provides considerable guidance to licensees with respect to working with employees to develop written policies on responsible beverage service. Not only did the Licensee allow one of its employees to serve in the Pub without a Serving It Right certificate, the Licensee has done very little to train its staff about what might be appropriate in terms of the number of drinks to serve per hour. The Licensee, by its own admission, has no written policies. The Licensee has no regular training for its employees. There was evidence of mandatory staff meetings but no minutes or agendas produced to show what was discussed. When asked, Server 3 said they discussed things like dress code, promotions in the Pub, keeping everyone up to date about things. Server 3 said, prior to the incident on August 27, 2011, there had been no issues raised about over-service.

None of the employees were aware of the Guide. The Licence states that the licence is subject to the terms and conditions of the Guide. Page 7 of the Guide highlights in a box labelled "Important!" that you (as a licensee) must take time to read this guide carefully and make sure your managers and staff are familiar with the information presented here . . . " The Licensee has failed in this responsibility.

No log book was produced for this hearing although there was some evidence from staff that an incident log book existed and that some staff had reviewed the log book and the incident log for August 27, 2011. The Guide (page 26) is clear in its directions to licensees to record incidents in a log book. The Serving It Right manual at page 31 refers to the importance of keeping an accurate incident log. The Licensee must produce such evidence if they wish me to consider it and not to draw an adverse inference from its absence.

I find that the failure to produce the incident log book and the unwillingness of the Licensee to allow the Liquor Inspector to interview its staff, without conditions or production of questions ahead of time, are factors to consider when imposing a penalty here. The Guide states at page 10 that management and staff must cooperate with liquor inspectors and police. This includes the production of records and witnesses when there is a potential for enforcement action. Perhaps if the Liquor Inspector had had an opportunity to interview the staff here, she may have modified her recommendation**.** In choosing to treat this as an adversarial court proceeding, the Licensee may have contributed to the delay in resolving this matter. I find that the Licensee's response to the Liquor Inspector's request to interview the employees involved indicates that the Licensee is not fully aware of its responsibilities as a Licensee. This is a regulatory administrative hearing intended to establish the truth about an alleged contravention. Licensees have an obligation under the terms of its licence to make every effort to comply with branch requests.

The complete absence of written policies and a program of regular training of staff about over-service are also factors for my consideration when considering the appropriateness of the penalty and the public interest. The Licensee and its staff testified about the regular staff meetings. There are rarely agendas and no minutes kept of staff meetings. The Supervising Director spoke of the younger generation's reluctance to read policies or directions. It can be a simple matter to post regular tips on over-service and communications between staff, or reminders about the house policies. The Serving It Right manual encourages staff and management to work together to

develop house policies. Regular tests or quizzes can help ensure the staff are following written policies.

I find that the death of Female Patron D should not be a factor in determining the appropriate penalty. However, the fact of the death shows the extent of the over-service in this particular situation. This woman's general intolerance of alcohol and the failure of the staff in the Pub to adequately monitor service and to cut it off at an earlier time regardless of signs of intoxication turned out to be a lethal combination.

The Licensee introduced evidence about the changes in the Pub since this contravention, including improved communication and processes to ensure staff are aware of what has been served when there are shift changes. These improvements are important, as the branch encourages voluntary compliance. However, after the fact changes are generally not a factor when determining an appropriate penalty for a contravention. I note that the Licensee still has no written policies. Any training appears to be on the job experience and observation. Therefore, I encourage the Licensee to draft and implement policies with the involvement of its staff.

The Licensee submits that no other branch decisions on section 43(2)(a) or (b) contraventions have resulted in a 30 day suspension penalty. I have reviewed the branch decisions submitted by the Licensee and agree that a 30 day suspension is an extremely unusual recommendation for a first contravention of this type. Previous branch decisions are not binding on me as the delegate of the General Manager. However two of the key goals in taking enforcement action are consistent application of penalties and fair and equitable decision making. Section 3.1 of the branch's *Compliance and Enforcement Reference Manual* refers to Schedule 4 which "ensures that all licensees within the province are subject to similar penalties for similar contraventions."

In the interests of treating all licensees in a consistent manner, I have reviewed the branch decisions cited by the Licensee and their facts to help to satisfy myself that it is in the public interest to impose a penalty beyond the range in the Schedule.

The Licensee has referred to the branch decision in *Earl's Restaurant*, EH10-165 ("*Earl's*") as being the most relevant for my consideration. In *Earl's*, the service was excessive. One of the patrons was found lying under the table unconscious. The paramedics were called and took him to hospital, while another aggressive patron was removed by the police. In his discussion of the appropriateness of the recommended penalty of ten days, the general manager's delegate referred to the licensee's written policies, the comprehensive training program for its staff, the administration of tests and regular meetings with staff. The guidance provided in its written policies was violated by the staff member who was later suspended over this incident. The general manager's delegate concluded that a penalty above the amount in the Schedule was necessary to emphasize to the licensee the seriousness of its omissions and to bring the licensee into compliance. He chose not to impose the recommended penalty of 10 days and instead imposed a suspension of 8 days.

In *Earl's*, the staff violated the written policy with respect to over-service. Earl's had a policy of transferring the responsibility for observing intoxication to a shift leader, after the service of two drinks to a patron. This was not done on the night of the incident that led to the contravention. The delegate of the general manager noted that, if this policy had been followed, it is unlikely that the incident would have happened at all.

In the present case, there were no written policies for the servers to violate. Instead, the Licensee relied on the Serving It Right manual and Server 3 did not even have the benefit of this training.

I note the testimony of the staff with respect to how a suspension will affect their income and I remind the Licensee that salaries can still be paid during a suspension. I recognize that tips often form a significant part of staff's income but also note that staff are always affected when suspension penalties are imposed.

On the facts of this contravention, I am not satisfied that it is in the public interest to impose a penalty of 30 days. I base this on the Licensee's compliance history noted above, my finding that staff took actions to remove the patrons once they observed the obvious signs of impairment in Female Patron D, and my finding that failure to call an ambulance in this case should not be a factor in imposing a penalty.

I have noted the failures of the Licensee here which include:

- Ensuring all its serving staff had the Serving It Right certificate
- Providing basic training on over-service
- Drafting written policies and reviewing with staff
- Testing staff on specific issues
- Providing an incident log book to the branch, and
- Reviewing the Guide with staff

I find that the Licensee disregarded its responsibilities both to its staff, its patrons, and to the branch. The failures of the Licensee led to the over-service in this case. I consider this contravention to be a threat to public safety and the well-being of the community. Therefore, I am satisfied that it is in the public interest to impose a penalty greater than that set out in the prescribed schedule. I believe that this higher penalty will send a message to this Licensee and others that the Licensee is responsible for running its establishment, and for ensuring that its staff are given guidance, are well trained and aware of the consequences of their actions.

I therefore find that it is in the public interest to order a penalty beyond the maximum in the Schedule, and I impose a suspension of ten (10) days.

ORDER

Pursuant to section 20(2) of the Act, I order a suspension of Liquor Primary Licence No. 158089 for a period of ten (10) days to commence at the close of business on Friday, October 18, 2013 and to continue each succeeding business day until the suspension is completed.

To ensure this order is effective, I direct that the liquor Licence be held by the branch or the Victoria Police Department from the close of business on Friday, October 18, 2013 until the Licensee has demonstrated to the branch's satisfaction that the suspension has been served.

Signs satisfactory to the General Manager notifying the public that the licence is suspended will be placed in a prominent location in the establishment by a branch inspector or a police officer, and must remain in place during the period of suspension.

Original signed by

Nerys Poole
Enforcement Hearing Adjudicator

Date: September 13, 2013

cc: Liquor Control and Licensing Branch, Victoria Office
Attn: Gary Barker, Regional Manager