BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

FILE NO. 2011:369:0032

An Inquest was held at Burnaby Coroner's Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates December 9-11, 2013

before Tara Devine, Presiding Coroner,

into the death of Campbell, Torben Timothy (Last Name, First Name, Middle Name) 29 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: September 12, 2011 at 12:21 pm

Place of Death: Abbotsford Regional Hospital (Location) Abbotsford, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Anoxic Encephalopathy

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Anaphylaxis

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Peanut Allergy

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 11th day of December AD, 2013.

Tara Devine
Presiding Coroner's Printed Name

Presiding Coroner's Signature

CAMPBELL — Surname

Torben Timothy — Given Names

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Tara Devine

Inquest Counsel: Rodrick MacKenzie

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: Correctional Service of Canada/ Mr. Paul Singh and Mr. Edward Burnet
Dr. Burke/ Mr. Raj Samtani

The Sheriff took charge of the jury and recorded 9 exhibits and 18 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

On September 5, 2011, Mr. Torben Timothy Campbell was an inmate at Matsqui Federal Correctional Institution in Abbotsford, BC. The jury heard that at approximately 7:30 pm, Mr. Campbell was in the living unit when he started to feel unwell. He approached a Correctional Officer and requested his Epi Pen, stating that he was having an allergic reaction. Mr. Campbell self administered the Epi Pen and requested to be taken to an outside hospital. The Correctional Officer informed his supervisor who called 911 and requested an ambulance. The Correctional Officer testified that while Mr. Campbell was being escorted to meet the ambulance, he was viewed to have red and bloodshot eyes and he stated that he was having difficulty breathing. His condition continued to deteriorate and Mr. Campbell self injected two more Epi pens prior to the ambulance's arrival. The Correctional Officer testified that there was some difficulty locating additional Epi pens during this time.

The ambulance arrived and drove in through the front gates to where Mr. Campbell and the Correctional Officer were waiting. The jury heard that shortly prior to the arrival of paramedics, Mr. Campbell became unconscious. Paramedics worked to stabilize Mr. Campbell and then initiated transfer to Abbotsford Regional Hospital.

CAMPBELL (Surname) Torben Timothy (Given Names)

The ambulance arrived at the emergency department at approximately 8:31pm. Emergency physicians took over medical treatment and referred Mr. Campbell's care to an intensive care physcian a short time after arrival. The intensive care physician testified that Mr. Campbell did not show a typical presentation for someone having an anaphylactic allergic reaction. Doctors did multiple diagnostic tests. The jury heard that a CT scan of his head diagnosed an anoxic brain injury due to swelling from a prolonged lack of oxygen to the brain. On September 12, 2011, Mr. Campbell's family was advised by doctors that there was no chance for meaningful neurological recovery and a decision was made to withdraw him from life support.

During the Inquest, the pathologist testified that the cause of death was due to anoxic encephalopathy due to anaphlaxis caused by a peanut allergy. The pathologist testified that he had conducted allergy testing as part of his analysis. These findings provided confirmation that an anaphalactic reaction had occurred. Evidence presented by the toxicologist indicated that the toxicological findings were non-contributory to death. The jury also heard medical testimony that in a small number of cases, the Epi pen is not effective in controlling an anaphalactic reaction.

Testimony during the Inquest focussed greatly on issues and policies related to the management of inmates with allergies. The jury heard that Mr. Campbell had suffered multiple prior allergic reactions at all institutions where he was incarcerated. At Matsqui Institution, institutional staff were aware that Mr. Campbell had a severe allergy to peanuts and exposure to peanuts products. He was also allergic to peas and fish. However, despite efforts to reduce his exposure, he continued to have issues with cross contamination. Mr. Campbell had suffered many prior allergic reactions while in custody and required treatment at an outside hospital on several occassions. The Chief of Food Services testified that due to his allergies, Mr. Campbell did not pick up food from the regular meal line, he picked up his meals directly from the kitchen where they were prepared and packaged separately. Additionally, Mr. Campbell was known to keep food items and utensils in his room consistent with his dietary requirements, but that he had no toaster or accessories for food preparation.

The jury heard that in the living quarters at Matsqui Institution there is a shared kitchenette where inmates are able to prepare snacks. The kitchenette contains a prep area with toasters and other kitchen utensils. The jury heard that inmates sharing this space are allowed to use peanut products in the shared kitchenette and that there is no other prep area in the living quarters that is peanut or allergen free.

CAMPBELL	Torben Timothy
Surname	Given Names

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Commissioner,
Correctional Service of Canada
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

1. Consideration be given to the development of policy that inmates on transfer with known anaphalaxis or allergy related concerns be referred to and assessed by an allergist and then re-assessed to address any changes in their condition or continued exposure concerns.

Coroner's Comment: The jury heard evidence that Mr. Campbell was not referred to an allergist and that he had multiple prior allergic reactions requiring medical assistance.

2. Consider that Chief of Health Services or designate be placed on an email distribution list for all medical related communications/memos and that a copy of all medical related communications be added to the inmate's permanent medical record.

Coroner's Comment: The jury heard evidence that the Institution physicians were not a part of the email distribution list.

3. Develop and implement refresher training for correctional staff that manage inmates with allergies. Consider that this training include information on types of allergens, cross contamination issues, typical andn atypical presentations, EPI Pen usage and a review of correctional policies regarding medical treatment of persons experiencing an allergic reaction or acute medical emergency.

Coroner's Comment: The jury heard evidence that correctional staff have different levels of knowledge pertaining to issues of exposure to allergens, allergic reactions, and appropriate medical treatment including use of the Epi Pen. The jury also heard that correctional staff is provided basic first aid training with a component in dealing with allergic reactions with no other supplemental training.

4. Consider implementing the use of an electronic medical records system that provides clinicians the ability to view a patient's complete medical history in a timely manner to assist them in their clinical decision making. Or, if not practical, to consider the implementation of a policy to ensure that inmates being transferred to an outside hospital for an acute or emergent medical event have their medical chart

made available to send to the outside hospital emergency department or intensive care unit (as applicable) for review.

Coroner's Comment: The jury heard evidence from the attending physicians at Abbotsford Regional Hospital that they did not have the benefit of viewing Mr. Campbell's medical chart when he was admitted to the hospital and having this information may assist them in more effectively treating and diagnosing patients.

5. Review current practices regarding staffing and access to medical information after hours (1900-0700 hours) and consider that Health Services establish an after hours contact number so that correctional staff are able to reach a medical professional in the case of an emergency. Additionally, consider that the Correctional Managers have access to the health unit to retrieve a medical chart in the event of a medical emergency that occurs after hours.

Coroner's Comment: The jury heard evidence that Health Services was closed between 7:00pm – 7:00 am (1900-0700 hours) and that there was no medical person available during these hours. Additionally, the jury heard that correctional staff was unable to access medical charts during these hours if needed.

6. Review current practices for food preparation and consider the option of providing a peanut free facility. Or, if not practical, consider the implementation of a common food preparation area on the range in the living quarters to be peanut/allergen free and that maintenance of these areas follow strict decontamination/cleaning protocols. Consider that this food area is only accessible to only those inmates with allergen concerns and that this is strictly monitored and enforced. If not practical, to adopt this in all institutions Canada wide, designate a few facilities across Canada that can have allergen free zones where inmates with severe allergies can be housed.

Coroner's Comment: The jury heard evidence that despite institutional efforts that there was no way to fully eradicate peanut allergen cross contamination issues unless there was a peanut-free institution. In addition, the jury heard that in the absence of this type of facility, the next viable alternative is to implement common food preparation areas that are peanut-free.

7. All inmate request forms addressed to Health Services are to be read and signed by the Chief of Health Services or designate and a response sent to the inmate in a timely manner.

Coroner's Comment: The jury heard that the Chief of Health Services may not be directly given inmate request forms for review and that there was no way to track whether the Chief of Health Services was aware of particular medical concerns.

8. Consider that institution physicians review current prescribing practices for the Epi Pen and in circumstances where medically appropriate that a second EPI Pen be available.

Coroner's Comment: The jury heard evidence that in Matsqui Institution Epi Pens are prescribed to only individuals with allergy/anaphylactic concerns and that there were no extra Epi Pens available on the living units. The jury also heard that in some cases, multiple Epi Pens are required to treat an anaphylactic reaction. A second Epi Pen available per each inmate may assist in ensuring a proper level of immediate care.

9. Consider that policy be developed to ensure that correctional staff are reviewing all email communications in a timely manner. This might be accomplished by having correction employees sign off on important memos pertaining to health and safety that are personally or electronically presented to them.

Coroner's Comment: The jury heard evidence that not all correctional staff have direct computer access and that some emails are not read. The jury also heard that there is no policy or procedure in place for supervisors to verify whether correctional staff is reading their email communications.