Ministry of Public Safety
and Solicitor General
Coroners Service
Province of British Columbia

File No. :2014:0380:0008

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

SURNAME	GIVEN NAMES
COWAN	CHERYL ANN

An Inquest was held at Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates January 11-13, 2016

before: Matthew Brown, Presiding Coroner.

into the death of COWAN (Last Name) Cheryl (First Name) Ann (Middle Name) 58 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: December 23, 2014 10:05 AM

Place of Death: St. Paul's Hospital (Location) Vancouver, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Anoxic brain injury

Due to or as a consequence of

Antecedent Cause if any: b) Cardiac arrest

Due to or as a consequence of

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

(2) Other Significant Conditions Contributing to Death: Hypothermia and chronic alcoholism

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

The above verdict certified by the Jury on the 13 day of January AD, 2016

Matthew Brown
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Matthew Brown
Inquest Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Vancouver Police Department/Bronson Toy

The Sheriff took charge of the jury and recorded 4 exhibits. 21 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 Findings 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 Findings and Recommendations.

The jury heard that Cheryl Ann Cowan worked as a teacher in the Vancouver area for most of her working life. She struggled with an addiction to alcohol which resulted in the loss of her job and when she separated from her husband in 2003, her struggle with alcohol continued. The jury heard that Ms. Cowan attended several treatment centers and suffered a number of physical health issues. In the months leading up to her death, Ms. Cowan received medical treatment for alcohol-related injuries as well as issues with respect to ongoing cellulitis and chronic skin issues. Her overall condition was complicated by the fact that she was homeless despite having a substantial sum of money available to her to support her own living arrangements.

The jury heard that in the early morning hours of December 15, 2014, a 911 call was placed from the home of Ms. Cowan's ex-spouse after she was found in the residence. When the Vancouver Police arrived, Ms. Cowan was found at the exterior of the house back door looking through a bag with the assistance of a lighter. The police officer who spoke with Ms. Cowan gave evidence that she was mumbling incoherently and that he could smell alcohol on her breath; there was an empty wine bottle found at her feet. When questioned, Ms. Cowan told the officer that she did not enter the home and that she came to the home to get some of her belongings. The police officer gave evidence that while Ms. Cowan appeared to be intoxicated, as their discussion continued, she appeared more lucid and coherent. When asked, she told the officer that she lives outside coffee shops and did not have a residence.

The police officer gave evidence that he spoke with Ms. Cowan's ex-spouse and his common-law spouse while at the residence. They expressed concern as a similar incident occurred on December 12, 2014 at which time the police were called and Ms. Cowan was removed from the premises. The couple expressed concern for the safety of those in the home as well as Ms. Cowan's well-being. Ms. Cowan was arrested for "assault by trespass" and placed in handcuffs.

While walking towards the patrol wagon, a second police officer joined and the two accompanied Ms. Cowan to the back of the wagon. The second officer, who was the driver of the patrol wagon, searched Ms. Cowan and found nothing of potential concern or harm on her and she was assisted by the officers into the back of the wagon. The officer gave evidence that Ms. Cowan was asked if she had thoughts of harming herself or others and she replied that she did not. The officer who initially met Ms. Cowan at the residence gave evidence that she did not appear to be under any physical or emotional duress during his time with her; she was able to walk to the patrol wagon on her own. He stated that upon her arrival at the city jail, he expected that Ms. Cowan would be assessed by a physician and a determination would be made if she required medical assistance.

The driver of the wagon gave evidence that he had a previous interaction with Ms. Cowan approximately two months earlier at which time she was found sitting outside a coffee shop in Vancouver. She was observed to have blood on her face and cuts to her nose which Ms. Cowan reported was from falling down. The officer couldn't recall if BC Ambulance Service was called but he did state that Ms. Cowan refused further assistance.

The police officer stated that the drive from the scene to the Vancouver City Jail took approximately 40 minutes which included one stop to drop off an individual who was in a separate compartment of the patrol wagon.

The police officer gave evidence that there are no cameras in the patrol wagon to monitor prisoners in the back of the wagon. He stated that there is a speaker box that acts as a "walkie talkie" such that he can communicate with the person being transported. The police officer stated that he did not have any verbal contact or physical view with Ms. Cowan during the drive; he also stated that there is no requirement in VPD policy to check on prisoners during their transports.

Upon arrival at Vancouver City Jail, the police officer parked in the sally port, exited the patrol wagon, and went into the jail to book Ms. Cowan into the facility; this took approximately 14 minutes. The police officer gave evidence that he returned to the wagon with a guard from the jail and upon opening the back of the vehicle, found Ms. Cowan lying on the bench on her side unresponsive. The police officer testified that he entered the wagon and checked for any signs of breathing or movement; he stated that Ms. Cowan did not appear to be breathing and did not respond to any stimuli. By this time, two nurses who work in the jail arrived to the sally port area. With the assistance of one of the jail guards, Ms. Cowan was removed from the patrol wagon, placed on the ground briefly and then moved to a wheelchair where one of the nurses appeared to check Ms. Cowan's vital signs. The police officer testified Ms. Cowan remained unresponsive and that she "appeared motionless". The police officer testified that Ms. Cowan appeared motionless during his interaction with her.

The police officer testified that while he felt qualified to perform cardiopulmonary resuscitation (CPR), he did not attempt to as medical professionals were available in the facility and would "defer to a higher authority" in reference to both the nurses and the physician. He testified that had he been on his own in

the community, he would have attempted CPR pending the arrival of emergency personnel. He testified that there is no requirement in VPD policy for police officers to conduct first aid including CPR.

One of the nurses who attended to Ms. Cowan gave evidence that she was called to the sally port by one of the jail guards. Upon arrival, the nurse stated that when she checked Ms. Cowan's vital signs, she was not breathing, her lips were blue and her eyes were open and pupils were dilated. She reported that she did not bring any emergency first aid equipment (which included an Automated External Defibrillator (AED)) with her as the incident was not called in as a "code blue". If a code blue had been called, this would have resulted in one or both of the nurses bringing the equipment to the sally port area.

The jury heard that one of the nurses left the sally port area to obtain the equipment. At the same time, the physician was called by one of the nurses to attend the area. Upon the arrival of the physician and nurse, Ms. Cowan was removed from the wheelchair and placed on the ground. At this point, there were upwards of 9 individuals in the sally port tending to Ms. Cowan.

The physician gave evidence that he was summoned to the sally port by a guard and prior to leaving the nursing station, he asked another guard to call an ambulance. When he arrived at the sally port, the physician stated that he was informed by the nurse that Ms. Cowan's pupils were fixed and dilated, that she had no pulse and she was cyanotic. He stated that he examined Ms. Cowan and in addition to the observations of the nurses, found that her skin color was grey, there was no chest movement, and she had no blood pressure and no circulation present. He stated that he checked her wrist and neck and found no pulse. He stated that these findings were consistent with someone who had died. He spoke with the police officer who drove Ms. Cowan to the jail and found out that she had not been seen for 30-40 minutes before being removed from the back of the wagon. Based on this, and in addition to his physical examination, he determined that Ms. Cowan had suffered a prolonged cardiac arrest and had died.

The jury heard that the nurses asked the physician if the AED or CPR should be done on Ms. Cowan but this was not done given the physician's assessment of Ms. Cowan.

The physician gave evidence that the ambulance personnel arrived a short time later and following a discussion with the attending paramedics, CPR was commenced with the assistance of a firefighter from the Vancouver Fire Department who had also arrived at the sally port. The physician testified that he had misgivings about his judgment in not providing resuscitation to Ms. Cowan and asked the emergency personnel to commence CPR.

The jury heard that two ambulances arrived at the sally port the first of which was the primary care paramedic. The paramedic testified that he was surprised to learn that no resuscitation had been attempted prior to their arrival. He stated that upon their arrival, he spoke with the physician who reported he was unsure if CPR should be started. The paramedic gave evidence that he began resuscitation efforts along with the firefighter with his focus on ventilation while the firefighter performed chest compressions and administered the AED.

A short time later, the second ambulance, the Advanced Care Paramedic, arrived at the sally port. The paramedic gave evidence that they took over primary care of Ms. Cowan and initiated cardiac life support which included intubation and intravenous medications which the jury heard are standard interventions for the treatment of someone in cardiac arrest. After a short period of time, Ms. Cowan was revived; she was transported to St. Paul's Hospital (SPH) by the advanced care team where her care was transferred to the emergency department staff. The jury heard that Ms. Cowan's condition remained poor throughout the involvement of the paramedics. The jury also heard from the paramedics about the importance of initiating CPR the moment someone is found unresponsive and not breathing to increase the health outcomes of an individual.

It should be noted that jury reviewed the entire video footage from when the patrol wagon entered the sally port to when Ms. Cowan was taken to SPH by ambulance.

Upon arrival at the emergency department at SPH, Ms. Cowan was assessed and found to be extremely hypothermic with a temperature of 31.2 degrees Celsius. A chest x-ray and computed tomography scan (CT) of her head were found to be normal at the time and a blood alcohol screen revealed that she was not intoxicated. The jury heard that she was stabilized and transferred to the intensive care unit (ICU) for ongoing care. Her treating physicians at the ICU told the jury that Ms. Cowan's condition deteriorated over the course of several days in hospital; more specifically, her decreased level of consciousness and lack of neurological responses suggested a severe anoxic brain injury. Repeated CT scans confirmed this and in consultation with the family, Ms. Cowan was provided comfort care until she died on December 23, 2014 at 1005 hours.

The underlying cause of Ms. Cowan's becoming unresponsive was unknown to the physicians who treated her at SPH. One of the physicians gave evidence that chronic alcoholism can place one at risk for a sudden cardiac event such as an arrhythmia or a seizure. At the same time, hypothermia can also cause a cardiac event. The physician gave evidence that Ms. Cowan suffered from infections to both of her legs which could cause sepsis and place one at risk for a sudden cardiac event. Both physicians gave evidence that the underlying cause of death was not known.

The jury heard from an emergency room physician and medical consultant to the BC Coroners Service. He provided a review of Ms. Cowan's medical history as well as course of treatment at SPH up to her death. He gave similar evidence to Ms. Cowan's treating physicians with respect to the risks of chronic alcoholism and hypothermia to the cardiac system. He stated that based on his review, the anoxic brain injury which occurs when one is deprived oxygen from the brain, was the result of Ms. Cowan having suffered a cardiac arrest due to a cardiac arrhythmia (i.e. abnormal rhythm of the heart) and that both hypothermia and chronic alcoholism contributed to this. The physician testified that a low body temperature can place one at risk for a cardiac arrhythmia and in this case, being in the back of the police wagon for a period of time, and then placed on the concrete floor for a period of time, could have been a factor. The temperature outside on the morning of December 15, 2014 was approximately 3.6 degrees Celsius.

The physician gave evidence related to best practices when it comes to performing CPR. He stated that basic CPR (i.e. chest compressions) is an effective procedure to increase the chances of people having a full recovery when found unresponsive and not breathing if they are attended to early enough. He stated that in this case, the fact that Ms. Cowan had fixed and dilated pupils was irrelevant and that best practice would suggest that CPR be commenced as soon as she was found unresponsive. CPR is meant to provide someone with breathing and circulation which provides oxygen and blood flow to the heart, brain and other organs.

The jury heard from an Inspector from the Vancouver Police Department (VPD) who is responsible for the operations and oversight of the Vancouver City Jail. He stated that since Ms. Cowan's death, and in addition to a previous Coroner's Inquest, there have been changes to the process when police officers arrive to the jail with prisoners. That is, upon arrival at the sally port, the police officer can ask for the assistance of a jail guard to help bring the prisoner to a pre-holding area. In effect, the prisoners are attended to as soon as they arrive; they are processed and then transferred to the jail staff. This new policy was instituted on January 1, 2016 and was sent to all staff via email. The Inspector also gave evidence that the VPD is currently reviewing their existing fleet of patrol wagons to determine the extent to which changes should be made which could include adding some form of monitoring device as well as heated and air conditioned compartments.

The jury heard from a Deputy Warden of the BC Corrections Branch with respect to the vehicles they use when transporting prisoners. He stated that they have a number of different vehicles used to transport prisoners depending on the number being transported at one time. While the vehicles do not have video, the driver of the transport can see and communicate with the prisoner(s). In the event of a medical emergency, the driver will contact 911 and depending on their own safety, enter the back of the vehicle to assist pending the arrival of emergency personnel. The jury also heard from a Senior Inspector of the BC Court Services Branch of the Ministry of Public Safety and Solicitor General, specifically the Sheriff's department about the types of vehicles they use to transport prisoners. He gave evidence that their vehicles are equipped with both video and audio which is monitored. Unlike the VPD vehicles which have one officer present, these vehicles are staffed with two Sheriffs in the front of the vehicle one of which is responsible for driving while the other monitors the video and audio. The fleet of vehicles are equipped with both heat and air conditioning.

The jury heard from the Chief Executive Officer (CEO) of the company contracted by the Vancouver Police Board and City of Vancouver that provides medical services to prisoners in the Vancouver City Jail. He provided an overview of the company policies and training provided to his staff prior to and during the initial phases of their employment with the company. He explained that all of the physicians who provide services for his company are physicians who are currently or previously worked as emergency room physicians in a hospital setting. Since Ms. Cowan's death, the company has changed its policy and have a physician available 24 hours a day 7 days a week regardless of the medical matter; this is in addition to the nursing staff already in place. In addition to this, the company provides a 2-day training along with on the job training and mentoring for new nurses where the nurse would shadow an

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existing one for a period of time. In terms of CPR training, staff are required to re-certify every two years.

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

JURY RECOMMENDATIONS:

To: The Chief Constable and to the Vancouver Police Board

1. That the Vancouver Police Department undertake a review to examine the existing training for police officers and guards with respect to basic first aid and current CPR protocol. This review should consider certification by an independent recognized third party, that this training be mandatory, and that certification be current for all police officers and jail guards.

Presiding Coroner Comment: *The jury heard that neither police officers, nor jail guards are required to maintain basic first aid beyond the requirements when initially hired and trained. The jury also heard that basic CPR performed in a timely manner is critical to increasing the health outcomes for someone who is found unresponsive and not breathing.*

2. That the Vancouver Police Department undertake a review to determine the placement of security cameras in all wagons (i.e. transport vehicles). This review should include an analysis of other jurisdictions that utilize this equipment and one that provides optimal surveillance and monitoring of the prisoners to ensure their safety and well-being during transport.

Presiding Coroner Comment: *The jury heard that members of the Vancouver Police Department are unable to see, hear or communicate with prisoners during transport from the scene of arrest to the jail. Evidence provided during the inquest provided examples of other provincial agencies that have the technology to be able to actively monitor prisoners during transport.*

To: The Chief Constable, to the Vancouver Police Board and to ROCKDOC Consulting Inc.

3. That scenario-based training covering emergency medical situations that may arise in jail and transport settings include jail guards, police officers, jail nurses and the jail physicians. This training would cover the duties, responsibilities and authorities of each individual when involved in a medical emergency to ensure that there is a clear understanding of each person's role.

Presiding Coroner Comment: *The jury heard that there was confusion with respect to the roles and responsibilities in the sally port. That is, the jury heard witnesses including police and jail guards express uncertainty about who was in charge of the sally port and who could make decisions about contacting nurses or emergency personnel in the event of a medical situation. The jury heard that some*

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of the medical professional such as the nurses conduct mock scenarios; however, these scenarios do not include others who are almost always involved in similar instances in the sally port.