Ministry of Justice

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.:2014:0380:0002

LLOYD	GREGORY DOUGLAS
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates Tuesday February 10th to Thursday February 12th

before: Dr. D. Kelly Barnard, Presiding Coroner.

into the death of LLOYD (Last Name) Gregory (First Name) Douglas (Middle Name) 43 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: February 13th, 2014 11:34am

Place of Death: Vancouver General Hospital (Location) Vancouver, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Severe Anoxic Brain Injury

Due to or as a consequence of

Antecedent Cause if any: b) Traumatic Asphyxiation

Due to or as a consequence of

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

(2) Other Significant Conditions Contributing to Death: ETOH abuse, severe depression, ongoing chronic pain and past head trauma

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

The above verdict certified by the Jury on the 12th day of February AD, 2015

Dr. D. Kelly Barnard
Presiding Coroner's Printed Name

Presiding Coroner's Signature

LLOYD	GREGORY DOUGLAS
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Dr. D. Kelly Barnard
Inquest Counsel:	Mr. Rodrick H. MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	City of Vancouver - Mr. Toy Dr. Carvalho, Dr. Fay, Dr. Chittock and Dr. Evans – Ms. Yee

The Sheriff took charge of the jury and recorded six exhibits. Twenty three 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.

Gregory Douglas Lloyd suffered with, depression, substance use and chronic pain secondary to workplace injury. These issues had escalated for him in the year prior to his death and were associated with instability in his relationships and housing situation. His friend described Mr. Lloyd as a kind and loyal person who had extreme mood swings and emotional instability when he was drinking heavily.

In November of 2013 Mr. Lloyd was hospitalized following a physical altercation while intoxicated. He suffered multiple significant injuries including head and chest trauma.

Mr. Lloyd was arrested at his apartment building on January 7, 2014 (a month prior to his death) after allegedly forcing his way into a neighbour's suite and assaulting two people, apparently without provocation. Vancouver Police Department report that he appeared to be heavily intoxicated at the time. After his arrest, Mr. Lloyd bashed his head against a wall repeatedly, and had to be physically restrained to prevent him from hurting himself further. Upon arrival at the city jail, he was found inside the prisoner wagon. He had brought his handcuffs to the front and was attempting to strangle himself with the drawstring of his hoodie sweatshirt. Police intervened and stopped him from harming himself further. He was taken by ambulance to hospital where he was assessed as not requiring further care. He was then taken back to the jail where he was held overnight. The arresting constables both testified that they did not feel that Mr. Lloyd was suicidal or depressed at this time. His emotional state was described as intoxicated and belligerent and they thought that his self- harming behavior was intended to result in admission to hospital rather than incarceration at the jail. One of the constables testified that he specifically spoke to Mr. Lloyd about the self- strangulation and Mr. Lloyd dismissed it as "no big deal". The officer determined that this incident did not warrant a flag on the checklist for "suicidal" in the PRIME system, the computerized information system used by the VPD. They did enter the flags for "violence", "alcohol" and "weapons".

Mr. Lloyd attended his family physician on February 4, 2014 with complaints of headache and pain which he related to the injuries that he had suffered in November. The doctor testified that Mr. Lloyd did not tell him about the arrest and associated events in January and that he had not received any medical records

from the emergency department documenting this incident. The doctor stated that he had been caring for Mr. Lloyd since 2008. His major problems were depressive symptoms (for which he had intermittently been prescribed antidepressant medications), alcohol and marijuana misuse and work related chronic pain and neuropathy in his hands. The doctor said that he had not made a referral for psychiatric assessment as he felt that the waitlists were prohibitive. He stated that he was not aware of any community programs available to Mr. Lloyd for substance misuse assessment or treatment.

Mr. Lloyd's friend and former roommate testified that Mr. Lloyd had attended a community addictions program on February 6, 2014. He was assessed by a community addictions worker and was put on a waitlist for an addiction treatment centre in Maple Ridge. Despite this, upset once more by worsening interpersonal conflict, Mr. Lloyd started to drink heavily on February 7, 2014.

On the afternoon of February 8, 2014 a call was made to the Vancouver Police Department by Mr. Lloyd's friend, concerned that Mr. Lloyd had been drinking heavily and was acting erratically and indicating that he might deliberately put himself in harm's way. The friend reported that Mr. Lloyd was planning an altercation with someone in a local park and he was worried for his safety. Soon after the friend called again to report that Mr. Lloyd had arrived at his apartment, a location Mr. Lloyd was under order not to attend following the incident the previous month involving the neighbours.

The first officer to arrive was the duty sergeant, followed shortly by two other officers. They reported that they had accessed the PRIME system noting the flags for alcohol, violence and weapons. Mr. Lloyd was apprehended without incident, searched and sat with one of the officers waiting for the police transport vehicle. The officer describes Mr. Lloyd as intoxicated but pleasant and cooperative at that point, discussing his situation and the likelihood of transfer to the pretrial facility. Mr. Lloyd's friend who had made the initial call to the police and was in the area during the arrest, reported that when Mr. Lloyd asked that his bootlaces be tied, the officer told him that they would be taken from him at the jail. None of the officers involved recalled that conversation. The officers reported that they had no concerns at all about suicidal ideation based on Mr. Lloyd's demeanor during the arrest.

The officer in charge of the transport vehicle arrived, repeated the physical search, placed Mr. Lloyd's belongings in a bag, and secured his hands behind his back per usual procedures. Mr. Lloyd was wearing boots with laces. The officer testified that he was concerned that Mr. Lloyd was cold and did not want him to be without his boots. At 16:31 hrs Mr. Lloyd was placed in one of the compartments of the transport vehicle. Another detainee was already in place in the other compartment.

The transport vehicle arrived at 16:40 at the "sally port" (enclosed intake yard) at the Vancouver City Jail. Excerpts of the closed circuit video footage of the yard documenting the following events between 16:40 and 17:26 were shown at the inquest.

The transporting officer then followed usual procedures; taking the prisoners' belongings into the jail and logging them in. He then returned to the vehicle, removed the other prisoner from the van, repeated a physical search in the designated area and took him into the jail for processing.

At 16:46 hrs he returned to the van to retrieve Mr. Lloyd. Upon opening the compartment he noted resistance and saw Mr. Lloyd suspended by a neck ligature from the grate in the back of the door, his

hands still handcuffed but now in front of him and his legs resting on the floor of the van. The officer then pulled the door open, with Mr. Lloyd still suspended. The officer attempted to hold Mr. Lloyd up and he shouted for help. Two correctional officers in the sally port, ran over to help. They continued to try to suspend the body until the transporting police officer recalled that he had a pocket knife which he used to cut the ligature, allowing them to lower Mr. Lloyd to the ground. They fully removed the ligature, identifying it to be his bootlaces and placed him in the" recovery position" on his side and called for a nurse. By this point there were several officers present and observing, no one initiated first aid procedures as they waited.

At 16:50 the nurse arrived. She testified that she had been called urgently from her office and ran to the scene without bringing equipment. She said that in retrospect she should have brought the resuscitation equipment from the nursing office with her, but this did not occur to her in the heat of the moment. The other nurse on duty was on break at the time. When she arrived at side of Mr. Lloyd she directed the police officers to remove the handcuffs, assessed him and finding no pulse, initiated chest compressions. As this was all occurring she directed one of the officers to call an ambulance. Another officer went to get the Automatic External Defibrillator (AED) and oxygen apparatus from the office. At some point during these events the nurse was told that Mr. Lloyd had been found hanging. She instructed one of the officers to go to the nurses' office to get the equipment but he was unable to enter the office, and had to find the other nurse to gain entry. By the time the other nurse arrived with the equipment the ambulance crew were coming into the sally port so the attending nurse decided to continue chest compressions until the first ambulance team took over CPR at 17:00 hrs. At no point did anyone else at the scene render any direct assistance. The attending nurse stated that she had not directly participated in the management of a cardiac arrest prior to this incident. She had graduated from nursing school earlier in the year and her only previous experience prior to her job at the jail was as a nurse in a children' s summer camp.

The initial ambulance crew was a basic unit and they undertook spinal precautions, applied the AED and inserted an oral "King" airway and initiated ventilation with a bag and mask. This is a device is inserted into the back of the throat to open the passage to the lungs and allow ventilation. The attendant testified that she was told that the patient had been found hanging and that in her training there had been no specific instructions or protocols for managing these types of injuries.

The Advanced Life Support paramedics arrived at 17:05 and took over the resuscitation. The crew included a paramedic with eight years of experience and his trainee. They were notified of the events and that the patient had been hanging. An intravenous line was established and the ECG reviewed showing no cardiac activity. They administered two doses of epinephrine. At 17:15 they recorded return of circulation. Despite this finding they proceeded at this time per protocol to undertake an endotracheal intubation. They testified that the definitive management of the airway is intubation and that they always attempt to have this secure prior to transport. They reported that they did anticipate some difficulty with this procedure as the history of a hanging made injury to the airway likely and there was obvious swelling around Mr. Lloyd's neck. The trainee attempted the initial intubation and was unable to advance the tube into the trachea, even with a bougie (a device used to help guide the placement of the tube). At that point the heart beat was lost and more epinephrine was administered. The pulse and blood pressure returned. Mr. Lloyd was loaded into the ambulance at 17:26 hrs. While travelling in the ambulance the experienced paramedic elected to perform a video intubation. He reported that he encountered considerable difficulty in advancing the tube past the vocal cords. The team arrived at Vancouver General Hospital at 17:35.

At VGH it was confirmed there was some ventilation, but the endotracheal tube was still not fully advanced and was only at the level of the vocal cords. On attempting to adjust it, ventilation was lost. This led to an emergency surgical procedure to restore the airway which revealed that the trachea itself had been torn and a cuffed airway was placed in the rent. The airway was stabilized and further investigations and subsequent surgery confirmed that he had fractured the cricoid bone and that the trachea was transected at this level and was separated from the larynx by approximately one centimeter. Following the repair of his airway Mr. Lloyd was transferred to the intensive care unit where it was determined that he had suffered a prolonged lack of oxygen causing irreversible brain damage. He died with family at his side at 11:34 hrs on February 13th, 2014.

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, Vancouver Police Department

1. That all patrol officers be required to maintain certification by a recognized third party entity in basic first aid and current CPR protocol and that this training be included as part of an officer's regular block training and that all certification be current.

Presiding Coroner Comment:

The jury heard that none of the officers initiated rescue procedures in the several minutes between the discovery of Mr. Lloyd in distress and arrival of the nurse. The current officer in charge of training testified that basic CPR training and ongoing certification were not a priority for the VPD as their procedure was to call for other first responders, fire or ambulance. Many of the health professionals at the inquest testified that delay of even a few minutes in the initiation of basic cardiopulmonary resuscitation can result in severe and irreversible brain damage. Basic CPR training is widely available and takes approximately four hours of training every three years for ongoing certification. This training is a standard requirement of most police forces, including the RCMP in BC.

2. Implement protocol which would direct VPD members to provide immediate assistance during medical emergencies while waiting for the arrival of any EMT responders.

Presiding Coroner Comment:

This follows from recommendation one, several minutes elapsed during which officers were seen on the video footage to be observing without offering assistance.

3. Ensure that appropriate first aid equipment and supplies be immediately accessible in all VPD vehicles, the sally port and jail. Ensure that the location of said equipment and supplies be standardized in all vehicle/vehicle type. Ensure that said kits or equipment be replenished in a timely manner. Assign appropriate personnel to ensure compliance.

4. Ensure appropriate first aid equipment and supplies are reviewed for adequacy and presence in all VPD managed buildings or locations.

Presiding Coroner Comment:

Multiple witnesses testified that they were confused about where to find the appropriate equipment in vehicles and that there was no consistent standard across the districts of the VPD. There was also no documentation of a procedure for the maintenance of an inventory, nor for regular checking and replenishment of these supplies.

5. Placement of ligature cutting tools similar to those used in correctional facilities in all prisoner transport wagons, dedicated locations within the sally port and inside the jail building. Orientation of said tools is provided to all transport wagon operators, jail guards, jail nurses and jail officers.

Presiding Coroner Comment:

The jury heard from medical experts that the most important intervention in a hanging incident is to cut the ligature immediately. There was confusion amongst the attending officers as to the location of an appropriate cutting tool. Correctional officers testified that since this death, these are now standard in facilities and vehicles and that staff in the BC Corrections Service are trained in their access and use.

6. Scenario-based training which would cover emergency situations that may arise in the jail and transport settings to be introduced and provided during annual block training. This training must include civilian and contracted staff. As part of this training, specific protocol for managing hanging situations should be provided due to the fact this is the most common method of suicide while in custody.

Presiding Coroner Comment:

Attendees, including contracted staff, at this critical incident testified that there was some confusion as to the role of various staff members and that they felt unprepared to function optimally as a team in these situations.

7. That supervision and observation of prisoners in the transport wagons be increased. Considerations:

a) Adequate lighting be present in each prisoner compartment of the transport vehicle at all times

b) The addition of a second person to assist in the transport and hand over process

c) The placement of security cameras in each compartment of the transport vehicle which would provide real time surveillance of the prisoners by one of the vehicle attendants or a remote location such as the jail.

Presiding Coroner Comment:

The jury heard that the VPD transport vehicles are staffed by only the driver. Although there is the option to listen via microphone to the passenger compartments there is no camera to directly observe. Mr. Lloyd was left unattended and unmonitored for 17 minutes, thus affording him sufficient time to bring his bound hands from behind him to the front, untie his bootlaces, use them as a ligature and hang himself from the grate. If these actions were observed the officer may have had an opportunity to intervene before Mr. Lloyd could injure himself. It was also explained that at no other time during incarceration is a detainee left unattended or unobserved for an extended period. In the BC Corrections transport vehicles there are cameras into the prisoner compartment and two officers attending to allow for one to monitor the passengers. Where detainees are

transported by arresting officers in police vehicles they can be directly heard and observed. It was also noted that there are no exposed grates inside the compartment of the BC Corrections vans.

8. A new category of Self Harm be added to the Vancouver Jail Arrest Report (JL8) and PRIME Considerations:
   a) Arresting officer to review Prime regarding past Self Harm incidents
   b) Take appropriate action for the purpose of preventing similar self-harm/suicidal acts up to and including removal of possible ligatures such as laces, belts or pull strings

Presiding Coroner Comment:

Officers testified that there were only limited options with regard to the flagging of concerns on PRIME. There was reported to be a distinction in the consideration of officers as to the hazard of potential for significant injury between people who are seen to be suicidal and those who are undertaking self-harming behaviours not intended to be fatal. Officers reported that they consider that the latter are used to for secondary gain, for example to cause the diversion of the detainees from jail to a health care facility in order to delay appearances. The jury heard that the previous attempt by Mr. Lloyd to strangle himself in the back of a transport van was deemed by the arresting officer at that time to represent an act intended to have him transported to hospital rather than jail and thus was not flagged as evidence of suicidal intent in PRIME. If a category for self-harm had existed and had been flagged, it may have alerted the arresting and then transporting officer as to Mr. Lloyd's previous success in slipping his restrained hands to the front of his body and the need for the removal of potential ligatures.

9. Review the Violence classification to be more specific
   Considerations:
   a) Sub category detailing type of violence
   b) Gradient system providing level of violence

Presiding Coroner Comment:

Officers reported that the "V " flag for violence is applied in a large proportion and wide variety of cases ranging from single episodes of mildly agitated or combative behavior to significant violence towards officers including the use of weapons. Because of its common use officer report that it is no longer considered extraordinary and does not necessarily change their approach to an apprehended person.

10. Review of the Alert mechanism used in PRIME to:
    a) Delineate clear responsibility for the assignment and documentation of the alerts
    b) Clarity with regard to the purpose and definition of the alerts and that they are meant to provide protection for police officers and ensure the safety for those taken into custody
    c) Provide specific notations in the remark section of PRIME such as the ability of the detained individual to move their hands to the front of their body.

Presiding Coroner Comment:

Several officers testified that there was some confusion as to the responsibility to post alerts in PRIME. It was also noted that indication that an individual had previously successfully slipped their cuffed hands from behind their back to the front would be useful in managing their arrest.

11. Review the current process of how an incident is recorded and flows between the JL8 occurrence Report and PRIME.

Presiding Coroner Comment:

The information regarding the first incident of attempted hanging was not entered in PRIME

12. Review practice of assigning the least experienced officer as a transport vehicle driver.

13. Review the possibility of adding an additional training officer.

Presiding Coroner Comment:

The jury heard that the ongoing training needs for the VPD were extensive and that the resources available to plan, oversee, deliver and evaluate the training are over stretched.

14. Ensure Jail Sergeant or acting Jail Sergeant has the code to the nurse's station.

Presiding Coroner Comment:

The jail staff could not get into the nursing office to access the emergency equipment.

To: The Vancouver Police Board and City of Vancouver

1. The contract for medical services in the jail will be reviewed to ensure that providers are adequately prepared for all duties required, in particular response to emergency situations.

2. Institute regular audits of the medical services provided under contract to be reviewed by an independent party of health care experts.

Presiding Coroner Comment:

The Inspector responsible for the jail indicated that the contract for the health care providers did not specify the level of experience or training required of professionals providing service through the contractor. The administration of the contract for medical services and the review of the quality of the services provided is based on administrative matters and the police administrators do not have the expertise to assess the adequacy of the medical services.

3. Conduct a review to ensure all pertinent information gathered from the 911 call is relayed to the police dispatch and then on to the attending officers.

Presiding Coroner Comment:

The jury heard that the attending officers were not aware of the concerns expressed by the original caller to 911 that Mr. Lloyd was deliberately putting himself in danger.

To: The BC Ambulance Services and BC Trauma Services

1. That these organizations institute the process for joint review of cases in order to support the ongoing multidisciplinary approach to quality improvement of trauma services; following the process from scene through to hospital or other care facility.

Presiding Coroner Comment:

The trauma surgeon who attended Mr. Lloyd reported that although there are separate quality review processes for the ambulance service and the hospital, quality assurance would be enhanced by a collaborative multidisciplinary review of the total path of trauma care from incident to treatment.

To: The College of Physicians and Surgeons

1. That all primary care physicians be reminded of their responsibility to be familiar with and establish referral relationships with agencies and individuals in their community, who are available to provide care for people with complex problems such as addictions, chronic mental health issues and other issues such as chronic pain management.

Presiding Coroner Comment:

Mr. Lloyd's family doctor testified that he was not aware of the resources in the community for the provision of addictions assessment and treatment services. Mr. Lloyd did find his own way to these services and was immediately referred for further treatment.

To: Vancouver Coastal Health

1. That it be mandatory to forward a copy of the "Emergency Discharge Summary" to the family physician within (3) three business days of a patient's discharge from hospital.

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Presiding Coroner Comment:

The records of the emergency visit for the care of the first hanging attempt were not provided to Mr. Lloyd's family doctor. The doctor testified that the information from the emergency department would have been helpful in the assessment and treatment of Mr. Lloyd at the visit four days prior to the incident that led to his death.