



CORONER'S COURT OF BRITISH COLUMBIA

held at Burnaby, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

ADOMAKO

SURNAME

GEORGE CLEMENT

GIVEN NAMES

We, the Jury, having been duly sworn and serving at the inquest, commencing on February 19, 2007 at Burnaby, British Columbia, and continued on the following dates February 20 and 21, 2007 into the death of George Clement ADOMAKO find that he came to his death at 0556 hours on the 4th day of October, 2003 at or near Vancouver, British Columbia

We find that the medical cause of death was (a) Acute cocaine intoxication.

DUE TO or as a consequence of, (b) _____

We, the Jury, classify the death as: Accidental Homicide Natural Suicide Undetermined

Table with 2 columns: Juror's Printed Name, Juror's Signature. Rows 1-5 for JUROR #1 to #5.

The above verdict received on the 21st day of February, 2007.

MARJ PAONESSA

Presiding Coroner's Printed Name

Maonessa

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age: 31 years Gender: Male Female
Date of Birth: December 20, 1971 Native: Yes No
Coroner's Case No.: 2003-263-0914 Post Mortem: Full External None
Police File No.: 03-255027 Toxicology: Yes No
Police Department: Vancouver Police Dept. Identification Method: Visual Other (specify below)
Court Reporter: Ogston Knull Reporting Svc. Identified by: Fingerprint comparison
Phone: (604) 924-3409 Premise of Injury: Police cells



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INTRODUCTION

The Inquest proceedings into the death of George Clement Adomako commenced at 0930 hours on February 19, 2007, at the Office of the Chief Coroner Courtroom and continued on February 20 and 21, 2007. Mr. Rodrick MacKenzie was counsel to the coroner. Ms. Catherine Kinahan represented the City of Vancouver and Ms. Angela Davies represented the Attorney General of British Columbia. Ogston Knull Reporting Services recorded the proceedings. Deputy Sheriff Mike Castelein took charge of the Jury and recorded the following exhibits:

1. Series of photographs, Vancouver Police Department Jail;
2. Vancouver Police Jail CD of audio statement and video footage of October 4, 2003;
3. Videotape of Vancouver Police Jail pre-hold and holding cell taken October 4, 2003;
4. Transcript of Vancouver Police statement of Alan Blais taken October 4, 2003;
5. Timeline, Vancouver Police Department Det. K. Nixon;
6. Floorplan, Vancouver Jail layout;
7. Vancouver Jail Arrest Form in use October 4, 2003;
8. B.C. Ambulance Crew Report, dated October 4, 2003;
9. St. Paul's Hospital Emergency Assessment Form dated October 4, 2003;
10. Registration of Death, George Clement Adomako;
11. Report of Postmortem Examination, George Clement Adomako;
12. Report of Provincial Toxicology Centre regarding George Clement Adomako;
13. Vancouver Jail Arrest Form, currently in use;
14. Vancouver Jail Policy/Procedure Manual.

The following witnesses testified at the Inquest:

1. Det. K. Nixon,
2. Cst. S. Dhaliwal,
3. Cst.. T. Leboutillier,
4. Cst. T. McLean, ERT,
5. Cst. R. Bell, ERT,
6. Insp. T. Schinbein
7. Cst. T. Zwissler
8. CO Negrin
9. CO D. Schweighardt
10. CO. G. Cuscito
11. Mr. Blais/statement
12. Ms. Zarina Sajoo, RN
13. Sgt. M. Tonner
14. Mr. J. Dhillon, EHS paramedic
15. Mr. I. Muir, EHS paramedic



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16. Dr. L. Gray, forensic pathologist, Vancouver Hospital
17. Dr. W. Martz, Provincial Toxicology Centre
18. Insp. Forsberg, Vancouver Police Department

INQUEST PROCEEDINGS

The following is a brief synopsis of the evidence presented at this Inquest. The purpose of these comments is to assist the reader to more fully understand the Verdict and Recommendations of the Jury. It is not intended to be considered evidence nor is it intended in any way to replace the Jury's Verdict.

The Jury heard evidence that at approximately 0216 hours on October 4, 2003, Vancouver Police Department Csts. Dhaliwal and Leboutillier responded to a 911 call about a 'fight with a gun and possible stabbing' near Fraser and Broadway Streets. The dispatcher also provided a detailed description of one of the assailants who had fled the scene. As the officers approached the area, they noticed a man matching the description walking eastbound on the north side of the 300 block of West Broadway. They approached the man who identified himself as George Clement Adomako. Mr. Adomako was compliant with their instructions and appeared to be uninjured and lucid.

Two Emergency Response Team (ERT) officers in the area also attended due to the serious nature of the incident reported on the air. Mr. Adomako was asked by the officers as he was being patted down whether or not he had any weapons or sharp objects on his person to which he responded no. ERT Officer McLean located a pellet gun inside Mr. Adomako's waistband during the search and he was immediately placed face down on the ground in order to effect a further search for weapons. A Leatherman knife and a canister of pepper spray were also located in his pockets. Mr. Adomako was placed under arrest for carrying a prohibited weapon. The other person involved in the fight was spoken to by police and determined to be uninjured. He admitted to being involved in an altercation with Mr. Adomako and that he had been pepper sprayed during their fight. He refused, however, to provide a written statement to police.

While waiting for the transfer wagon to arrive, Cst. Dhaliwal had a discussion with Mr. Adomako and learned that he had been in the country approximately ten years and had gotten involved with using and selling drugs. He indicated his desire to change his lifestyle. He denied being in an altercation. Cst. Dhaliwal noticed that the inside of Mr. Adomako's mouth appeared to be coated with a white film although he denied ingesting any drugs despite repeated questioning by all the officers. Mr. Adomako indicated he was well aware of the danger of swallowing drugs and was just thirsty.

Cst. Dhaliwal spoke to Inspector Schinbein at the scene about calling an ambulance to the scene to assess Mr. Adomako as he had been in a fight and that he may have ingested drugs. Inspector Schinbein spoke to Mr. Adomako who again denied he had ingested any drugs. He felt that Mr. Adomako was forthright in his response and did not appear to be agitated or intoxicated and was not visibly injured. He advised the transfer wagon driver, Cst. Zwissler, to tell the nurse on arrival at the jail that Mr. Adomako may have ingested drugs.



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It was his expectation that Mr. Adomako would see the nurse shortly after his arrival.

Cst. Zwissler advised the Jury that Mr. Adomako was already handcuffed with his arms behind his back upon his arrival at the scene. He was advised of the charges by the officers and noted some white film around Mr. Adomako's mouth. He overheard Mr. Adomako tell one of the officers it was from spitting. Mr. Adomako appeared to be lucid and communicative. Cst. Zwissler stated that the instruction he received from Inspector Schinbein was that if Mr. Adomako needed to see the nurse, that a nurse was available at the jail. A Vancouver Jail Arrest Report ('Jail 8') was completed by Cst. Dhaliwal and given to Cst. Zwissler regarding Mr. Adomako's transfer. There were no medical concerns recorded on the form.

At the time of this incident, Vancouver Jail was staffed with B.C. Corrections staff with a senior police officer and a senior Corrections officer in charge. Two nurses were also on staff 22 hours per day to assess each prisoner after they are searched and booked in. If the need arises, staff can summon the nurse from her adjacent workstation to assess prisoners in the event of a medical emergency. A physician is also available during the week days if the need arises. Prisoners are monitored by physical checks in the cell door windows by staff and by visually checking a bank of video monitors in the room next to the book in counter. There is also a central control office in a different location in the building where all the building monitors are observed. This office is also responsible for remote access to outside doors into the complex. No audio monitoring is present at either office location.

Cst. Zwissler made two other pickups and arrived at the Vancouver Jail loading bay at approximately 0355 hours. The prisoners were removed from the van and placed in the Pre-Hold cell. Cst. Zwissler placed all the Jail 8 forms in the in-tray at the book in counter. Prisoners are held in the monitored Pre-Hold cell while remaining handcuffed until they can be individually searched and brought into the jail area for the book in procedure. Mr. Adomako was observed to be standing for a period of time and then sitting on the floor and kicking at the door into the cell area. He remained in this cell for approximately 27 minutes before he was taken to the search area where he was directed to remove his clothing and was searched by Corrections staff.

Once the search was completed, Mr. Adomako was provided with a paper jumpsuit to wear. Corrections Officers Schweighardt and Negrin advised the Jury that Mr. Adomako was compliant with their instructions during the search process. No drugs or paraphernalia were located. He said he was thirsty and was taken to the sink area where he was witnessed to drink a large amount of water. The officers both stated that this was not unusual for prisoners to be thirsty as they often arrive to cells dehydrated for a variety of reasons. Mr. Adomako did not appear to be intoxicated at this time. Mr. Adomako was then placed in a holding cell with two other prisoners. These cells are video monitored and he was noted to be sitting on the floor in front of the door kicking it at one point. He remained quite active in the cell standing and then sitting on the floor and then lying on the floor with his feet by the door.

At 0455 hours, approximately 28 minutes after he was placed in the cell, one of the officers observed Mr. Adomako on the video monitor appearing to seizure on the cell floor. He immediately summoned other staff



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and the nurse to attend the cell. A 911 call was placed to summon an ambulance. Mr. Adomako was removed from the cell and placed on the floor in the hallway outside the book in counter.

The officers told the Jury that Mr. Adomako demonstrated tremendous strength and it took four or five of them to control him. They eventually placed him in handcuffs and leg restraints in order for the nurse to safely assess him. She observed blood spraying from his mouth as he flailed around but was able to administer a shot of Ativan in an attempt to calm him down. She testified that the Ativan did not appear to have any effect.

Emergency personnel arrived on scene a short while later. They initiated an IV line and Mr. Adomako was placed on their stretcher with assistance from staff. He was noted to be unresponsive but breathing on his own. As they were loading Mr. Adomako into their vehicle, he was observed to stop breathing. Cardiopulmonary resuscitation was initiated and he was taken to St. Paul's Hospital Emergency. Despite all efforts, Mr. Adomako was pronounced dead by an emergency room physician at 0556 hours.

Dr. Laurel Gray performed the postmortem examination on Mr. Adomako and advised the Jury that she did not identify any significant natural disease or trauma to cause his death. There was evidence that Mr. Adomako had bitten his tongue, typically seen with seizure activity. She concluded that Mr. Adomako died as a result of acute cocaine intoxication. Toxicology samples were submitted to the Provincial Toxicology Centre for testing. Dr. Martz told the Jury that the level of cocaine was within the range considered to be lethal and was consistent with being ingested within two to four hours of death. Dr. Martz advised the Jury that if Mr. Adomako had swallowed a large amount of cocaine, he may not have demonstrated any unusual symptoms until the acute effect of the cocaine caused him to seizure and suffer a sudden cardiac arrest. He told the Jury that there is no antidote for cocaine overdose and he could not say with certainty whether earlier medical intervention in the form of intensive life support measures would have been successful, given the high levels detected in Mr. Adomako's system.

The Jury heard evidence that since April of 2006, the responsibility for supervising and staffing the Vancouver Jail has been turned entirely back over to the Vancouver Police and that B.C. Corrections Officers no longer staff the facility. The VPD policies and procedures manual is currently being adapted from the one used by Corrections with changes already being made to the areas related to medical assessment of prisoners. There have been a number of changes to the 'Jail 8' Form to include more detailed information about each prisoner in a check box format. There is currently no box on the form to identify suspicion of drug ingestion. As well, the forms must be handed off to an officer at the jail and not just left in the tray.

At the end of their deliberations, the Jury classified the death of George Clement Adomako as accidental and put forward the following recommendations to the Chief Coroner of British Columbia for distribution.

Marj Paonessa
Marj Paonessa
Presiding Coroner



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JURY RECOMMENDATIONS

To: Chief Constable Jamie Graham
Vancouver Police Department
312 Main Street
Vancouver, BC V6A 2T2

1. On 'Jail Arrest Report', Section 'Medical Remarks' or appropriate Section, that a check box indicating suspicion of drug stash ingestion be included.
2. That when a file coordinator requests videotape footage of an incident, that all footage related to that incident be collected and subsequently preserved.
3. Need to investigate the use of audio as part of the jail monitoring system.

To: Ms. Debbie Sutcliffe
Ministry of Labour and Citizens' Services
Accommodation and Real Estate Services
3350 Douglas Street
Victoria, BC V8Z 3L1

4. Employ the highest quality of video cameras and real time storage of data that is date stamped.