CORONER'S COURT OF BRITISH COLUMBIA

held at KAMLOOPS, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

ELLIS	Robert Michael
SURNAME	GIVEN NAMES

We, the Jury, having been duly sworn and serving at the inquest, commencing on 19 June 2007 at Kamloops, British Columbia, and continued on the following dates 20 June 2007 into the death of Robert Michael Ellis find he came to his death at approximately 1558 hours, on the 13 day of October AD, 2006 at or near Kamloops, British Columbia.

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Subdural hematoma

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) A head injury

DUE TO OR AS A CONSEQUENCE OF

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

(2) Other Significant Conditions Contributing to Death:

CLASSIFICATION OF THE EVENT ☒ ACCIDENTAL ☐ HOMICIDE ☐ NATURAL ☐ SUICIDE ☐ UNDETERMINED

The above verdict certified by the Jury on the 20 day of June AD, 2007.

TONIA GRACE
Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age: 45
Date of Birth: 4 August 1961
Coroner's Case No.: 2006:456:0050
Police File No.: 2006-31312
Police Department: Kamloops RCMP
Court Reporter: Andrew Machin

Phone: 250-828-1077

Gender: ☒ Male ☐ Female
Native: ☐ Yes ☒ No
Post Mortem: ☒ Full ☐ External ☐ None
Toxicology: ☒ Yes ☐ No
Identification Method: ☐ Visual ☒ Other (specify below)
Identified by: Fingerprint analysis

Premise of Injury: Unknown

Premise of Death: Hospital

CORONER'S COURT OF BRITISH COLUMBIA

held at KAMLOOPS, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

ELLIS	Robert Michael
SURNAME	GIVEN NAMES

INTRODUCTION

This inquest into the death of Robert Michael Ellis commenced 0930 hours on June 19, 2007 at Kamloops Court House, Kamloops and continued on June 20, 2007. Dr. S. Pilley was counsel to the coroner. Ms. H. Roberts appeared on behalf of the Attorney General of Canada and Mr. J. Grover appeared on behalf of the City of Kamloops. Deputy Sheriff J. Boomer took charge of the jury and recorded the following exhibits:

1. Photographs (numbered 1-4)
2. Cell block plan of Kamloops RCMP detachment
3. Log sheet from 12/10/06
4. Log sheet from 13/10/06
5. Autopsy report with toxicology calculation report
6. Registration of death

The following witnesses testified:

1. Wade Bayntun – bookstore employee
2. Cst. Connie Buckle – arresting officer
3. Cpl. Gary Macahonic – officer assisting Ellis to cells
4. Clayton Vandenham – cell guard
5. David Tompkins – cell guard
6. Rosalbo Vecchio – cell guard
7. Barry Kenoras – cell-mate
8. Cpl. Bob Jones – RCMP officer responding to cells
9. Jeffrey Sopel – BCAS attendant
10. Dr. Paul Linden – ER physician
11. Dr. Darryl McNaughton – Pathologist
12. Dennis McKinley – Cell guard supervisor
13. Cst. Sabrina Mill – RCMP primary investigator

CORONER'S COURT OF BRITISH COLUMBIA

held at KAMLOOPS, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

ELLIS	Robert Michael
SURNAME	GIVEN NAMES

PRESIDING CORONER'S COMMENTS

The following is a brief synopsis of the issues reviewed during the 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.

At around 1600 hours on October 12, 2006, Constable Connie Buckle responded to a call made by an employee of a bookstore in Kamloops requesting assistance as a male was lying on the ground blocking the rear exit of the store. When the officer arrived at around 1615 hours, the male – later identified as Robert Michael Ellis – was initially unresponsive to her requests to get up. He then did get up by pulling himself up by using the wall for assistance. She determined that he was intoxicated due to his appearance, manner and the smell of alcohol. An empty bottle of wine lay near to him. She arrested him for being drunk in a public place. An employee of the bookstore, Wade Bayntun, helped her walk Mr. Ellis to the police car. Though mainly incoherent, Mr. Ellis was compliant and there was no altercation. He displayed no signs of injury.

At the Kamloops police detachment, Mr. Ellis was taken directly to cell FT1 aided by a number of other police officers. He was put on the floor and some belongings removed. This was at approximately 1630 hours. He was alone in the cell which was equipped with a video camera. Only one cell guard, Clayton Vandenham was on duty when Mr. Ellis came into the cells at 1635 hours. A second cell guard, David Tompkins came on duty at 2200 hours. This was a typical staffing level. During anticipated quieter times, it was common for only one guard to be on duty.

When Mr. Vandenham finished his shift at 2400 hours, guard Rosalbo Vecchio came on duty. All three cell guards as well as their supervisor (Dennis McKinley) and Cpl. Bob Jones stated that a guard was required to check on the prisoners at intervals of no more than 15 minutes. Both guards (Vandenham and Vecchio) who were responsible for checks on Mr. Ellis stated that they had physically checked on him through the cell door window at intervals of no more than 15 minutes but had not noted anything wrong as he was heard breathing on each occasion. These checks were required to be entered into the cell logs though it was permitted practice to simply initial sections of the log to show this had been done rather that using the more typical words "cells are okay".

In addition to checking on prisoners, evidence was given that guards performed a number of other duties including cleaning, feeding prisoner, answering the telephone and general clerical/administrative duties.
The guard room was equipped with two monitors that showed images of all the cells and the hallway. Though each cell camera also recorded footage, the equipment did not allow for viewing past images unless the whole system was shut down. This meant that the guards were unable to go back to look at events they may have missed while attending to other duties, should that be necessary.

Evidence was given by both Cpl. Bob Jones and Dennis McKinley that intoxicated prisoners are ordinarily released without charge after around 8 hours but that there was no timeline policy. Sometimes prisoners, usually the homeless, were allowed to stay longer. It was adduced that guards were not allowed to enter the cells without an RCMP officer present, except in cases of extreme emergency. This policy was established for safety reasons.

At 0120 hours on October 13, 2006, Barry Kenoras was also placed in cell FT1. Video footage corroborated Mr. Kenoras' evidence that at no stage did he harm or injure Mr. Ellis.

At 0430 hours, cell guard Vecchio and RCMP officer Cpl. Jones entered cell FT1 in order to release Mr. Ellis. Coincidentally it appeared at around the same time that Cpl. Jones had decided to release Mr. Ellis, his cell-mate, Mr. Kenoras, had become concerned about Mr. Ellis and had banged on the cell door requesting assistance for him. When Mr. Ellis did not respond to efforts to rouse him, it was decided that an ambulance should be called.

Prior to Cpl. Jones and cell guard Vecchio entering the cell FT1 and unsuccessfully attempting to rouse Mr. Ellis, they had no concerns about his well-being. He had been considered a typical intoxicated man sleeping off his alcohol consumption. They had relied on the fact that he was breathing to determine that he was okay. It had not been noted that he had been sleeping for a long time in the same position without moving. There was no policy or protocol about rousing intoxicated sleeping prisoners after a certain length of time or monitoring prisoners who had little or no movement after a certain period.

At 0445 hours, three attendants from the BC Ambulance Service arrived. Mr. Ellis was noted to be breathing on his own but was unresponsive. After approximately 20 minutes of medical assistance, they decided to transport Mr. Ellis to the Royal Inland Hospital (RIH) in Kamloops. Upon arrival at RIH, the emergency physician Dr. Linden assessed Mr. Ellis and sent him for a CT scan. The scan revealed a terminal subdural hematoma which, by that stage, was too extensive for medical treatment. Comfort care only measures were then instituted. Mr. Ellis was pronounced deceased at 1558 hours on October 13, 2006.

An autopsy was conducted on October 17, 2006 by Dr. Darryl McNaughton. He determined the cause of death was a subdural hematoma. He also noted an 11cm linear right temporal skull fracture. He considered that the hematoma and fracture was likely to have been caused by blunt force head trauma – most likely a fall. He considered they were likely to have happened at the same time. He further stated that the injuries were consistent with falling backwards and striking either the back or right side of the head. Aside from some slight swelling and a faint contusion around the right eye, there were no other injuries noted by Dr. McNaughton. Moreover, he confirmed that there was no injury externally visible relating to the skull fracture. He determined that the subdural hematoma was likely to have been sustained 12-24 hours prior to death. The evidence had shown that Mr. Ellis had been in custody for 23 ¾ hours when he died.

Dr. McNaughton also gave evidence that alcohol had been detected in an ante-mortem blood samples taken at from Mr. Ellis at 0550 hours and 0610 hours at RIH. These readings enabled a back calculation which showed that Mr. Ellis would have been heavily intoxicated at the time of arrest and was likely to have had an alcohol level that was equivalent to the consumption of approximately 2 bottles of wine.

Three selected parts of the video cell footage was shown to the jury:

-Firstly, they viewed Mr. Ellis's arrival at the police detachment and placement into the cell.
-Secondly, they then saw that at 1700 hours, Mr. Ellis got up by using the toilet to pull himself up and then fell straight backwards striking his head on the concrete floor .
-Thirdly, they saw events in the cell from 0424 hours until 0505 hours on October 13, 2006. This included Mr. Kenoras banging on the cell-door, the arrival in the cell of Cpl. Jones and the cell guard Rosalbo Vecchio and their attempts to rouse Mr. Ellis through to the arrival of the BCAS attendants.

The fall at 1700 hours that had been captured on the video footage had not been witnessed by the cell guard, Clayton Vandenham. He gave evidence that he must have been engaged in other duties at that time and was not watching his monitor. After the fall, Mr. Ellis remained on the floor for approximately 30 minutes without moving. From 1730 hours until 1835 hours Mr. Ellis was seen to move about on the floor before then lying down still. Evidence from the RCMP Primary Investigator, Cst Sabrina Mill confirmed that after 1835 hours, Mr. Ellis was not seen to move. This fall happened almost 23 hours before death and fit into the time frame adduced by Dr. McNaughton i.e. that Mr. Ellis was likely to have suffered his fatal head trauma 12-24 hours before his death. Dr. McNaughton also confirmed that the location of the skull fracture was consistent with a fall resulting in the head being struck on the back.

Cst. Mill also gave evidence that there were no other notable events recorded on the cell footage other than those shown to the jury (listed above) and that at no stage had anyone, including Barry Kenoras, entered the cell and harmed Mr. Ellis.

After deliberation, the jury classified the death of Robert Michael Ellis as accidental.

Pursuant to Section 3(2)(d) 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:

....

Tonia Grace
Presiding Coroner

RECOMMENDATIONS OF THE JURY

To: Mr D. McKinley
Guard Supervisor,
Kamloops RCMP Detachment
560 Battle Street
Kamloops, BC
V2C 6N4

To: Mayor Terry Lake
City of Kamloops
7 Victoria St West
Kamloops, BC
V2C 1A2

To: Deputy Commissioner Gary Bass
RCMP Commanding Officer
E-Division
657 West 37th Avenue
Vancouver, BC
V5Z 1K6

1. We recommend that the log sheet format and recording system be reviewed by the guard supervisor in consultation with E-Division to ensure standardization, consistency and accuracy of information recorded.

To: Deputy Commissioner Gary Bass
RCMP Commanding Officer
E-Division
657 West 37th Avenue
Vancouver, BC
V5Z 1K6

To: Honourable George Abbott
Minister of Health
Ministry of Health
1515 Blanshard Street
Victoria, BC
V8W 3C8

2. We recommend that "close watch" protocol be expanded to include a definition of acceptable time for "little or non movement" (to be done by RCMP in consultation with Ministry of Health)

To: Mayor Terry Lake
City of Kamloops
7 Victoria St West
Kamloops, BC
V2C 1A2

3. We recommend to review and purchase a state-of-the-art recording and viewing system that will facilitate simultaneous playing/recording of activities in the cell block