BRITISH COLUMBIA

CORONER'S COURT OF BRITISH COLUMBIA

held at **Penticton**, British Columbia

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 11 April, 2007 at Penticton, British Columbia, and continued on the following dates 12 April, 2007 into the death of NEMECHEK, Albert William find he/she came to his/her death at approximately 18:00 hours on the 7th day of November, AD, 2004 at or near Penticton, British Columbia.

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Severe pneumonia

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

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: Substance abuse & prior medical history

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

The above verdict certified by the Jury on the 12th day of April AD, 2007.

T.E. CHICO NEWELL
Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age:	76 years	Gender:	☒ Male	☐ Female	
Date of Birth:	30 March, 1928	Native:	☐ Yes	☒ No	
Coroner's Case No.:	2004:557:0090	Post Mortem:	☒ Full	☐ External	☐ None
Police File No.:	2004-16369	Toxicology:	☐ Yes	☒ No	
Police Department:	RCMP Penticton	Identification Method:	☒ Visual	☐ Other	(specify below)
Court Reporter:	Mr. Dave Wilson	Identified by:	Spouse		
Phone:	250-490-2490	Premise of Injury:	Public Place		
		Premise of Death:	Hospital		

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

NEMECHEK	Albert William
SURNAME	GIVEN NAMES

INTRODUCTION

This inquest into the death of Albert William Nemechek commenced 0930 hours on April 11, 2007 at Penticton City Council Chambers, Penticton, BC and continued through April 12, 2007. Dr. Sydney Pilley was counsel to the Coroner. Ms. Helen Roberts appeared on behalf of the Attorney General of Canada (representing the RCMP). Ms. Mailyne Ouellet appeared on behalf of the Attorney General of British Columbia (representing the Ministry of Health and the BC Ambulance Service). Deputy Sheriff Darcy McGifford took charge of the jury and recorded the following exhibits:

1. Statement of Phyllis NEMECHEK, Spouse
2. Book of RCMP scene photographs
3. Statement of George Ryan LEZARD, Companion
4. Statement of Jason Robert SQUAKIN, Companion
5. Statement of Monty PAUL, Companion
6. Statement of Laurelle DOERSAM, BC Ambulance Service Paramedic
7. Autopsy Report
8. Registration of Death, Albert William Nemechek

The following witnesses testified:

1. Cst. Eric RENSBY, RCMP Penticton
2. Mr. Ian ESSON, Community Policing Officer
3. Mr. Thomas DAVIS, BC Ambulance Paramedic
4. Dr. Yves CLOUATRE, Penticton Regional Hospital Intensivist
5. Dr. Susan TEBBUTT-SPIERS, Penticton Regional Hospital Forensic Pathologist
6. Cpl. Bill BIRNIE, RCMP Kelowna

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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.

INQUEST PROCEEDINGS

It was learned that on October 28, 2004 a patrolling RCMP Penticton constable found Mr. Albert William Nemechek unresponsive lying on the ground in an open public/commercial area. He was with a group of two companions and it was determined that all had been consuming alcohol. The constable believed that Mr. Nemechek was in a state of alcohol impairment such that he was not capable of looking after himself. In the process of taking Mr. Nemechek into custody (Liquor Control & Licensing Act), the officer called for paramedics to attend. The paramedics subsequently assessed Mr. Nemechek and established that he was suitable for transfer to jail. Mr. Nemechek was loaded into the rear of the police vehicle. The officer then drove a distance of no more than 50 metres when he noted Mr. Nemechek to be unresponsive. The officer stopped the vehicle and directly assessed Mr. Nemechek. As it was evident that Mr. Nemechek was in cardiac arrest, a call was made for paramedics to return and resuscitative efforts were undertaken. Mr. Nemechek was loaded into the ambulance and transferred to Penticton Regional Hospital Emergency Department where he was received in full cardiac arrest. Subsequent medical intervention re-established cardiac function. Blood specimens were collected for diagnostic purposes. Toxicology screening was not indicated. Mr. Nemechek was maintained on continuous respiratory support. He was diagnosed with an anoxic encephalopathy secondary to a prolonged period without adequate oxygen supply. He was transferred to the Intensive Care Unit with a guarded prognosis. In consult with the family, a palliative order was established. Mr. Nemechek later died in hospital on November 7, 2004. Mr. Nemechek had a significant medical and social history that put him at risk for a sudden cardiac event.

From the findings at autopsy, the forensic pathologist identified the immediate cause of death as severe pneumonia due to gastric aspiration in a background of pronounced ischemic changes within the myocardium and severe hypoxic encephalopathy as a consequence of a sudden cardiac event of unknown etiology.

The Jury found the cause of death to be severe pneumonia. Substance abuse and prior medical history were found to be significant conditions contributing to the death. The classification of death was natural. The Jury put forward the following recommendation to the Chief Coroner of British Columbia.

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NEMECHEK	Albert William
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Pursuant to Section 3(2)(d) of the Coroners Act, the following recommendation is forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

T.E. CHICO NEWELL, A Coroner
in and for the Province of British Columbia

RECOMMENDATIONS OF THE JURY

To: Terry Smith
Chief Coroner
MetroTower II, Suite 800 – 4720 Kingsway
Burnaby, B.C. V5H 4N2

To: Interior Health Authority
Attn: Mr. Murray Ramsden, CEO
220 – 1815 Kirschner Road
Kelowna, BC V1Y 4N7

1. Standard protocol should be to perform toxicology tests upon arrival at hospital trauma unit. Documentation to patient's file and copies to coroner and forensic pathologist.

Background to Recommendation

The inquest heard the of the hospital's practice to discard blood specimens after a 7 day period post admission. The forensic pathologist identified the issue of not having the essential benefit of the use of the original blood specimens for toxicology in consideration of the final diagnoses relating to the cause of death. It was identified that in similar future circumstance, when a patient is admitted with a grave prognosis, that a change in current practice of blood specimen retention in hospital, to ensure the pathologist would ultimately have the fundamental benefit of full toxicology towards the comprehensive clinical determination of the cause of death, would certainly be warranted.