BRITISH COLUMBIA

CORONER'S COURT OF BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 15 May 2007 at Nanaimo, British Columbia, and continued on the following dates May 16 & 17, 2007 into the death of Jason Christopher Stodgell find he/she came to his/her death at approximately 0100 hours, on the 19th day of May AD, 2006 at or near Nanaimo, British Columbia.

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) DRUG INTOXICATION OF METHADONE AND MORPHINE

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:

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

The above verdict certified by the Jury on the 17th day of May AD, 2007.

ROSE STANTON
Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age:	30	Gender:	☒ Male	☐ Female	
Date of Birth:	27 January 1976	Native:	☐ Yes	☒ No	
Coroner's Case No.:	2006-0122-0040	Post Mortem:	☒ Full	☐ External	☐ None
Police File No.:	2006-18507	Toxicology:	☒ Yes	☐ No	
Police Department:	RCMP Nanaimo	Identification Method:	☒ Visual	☐ Other	(specify below)
Court Reporter:	Verbatim Words West Ltd.	Identified by:	Nanaimo Correctional Centre Staff		
Reporter Phone:	604-591-6677	Premise of Injury:	Nanaimo Correctional Centre		
		Premise of Death:	Nanaimo Correctional Centre		

POSTED

CORONER'S COURT OF BRITISH COLUMBIA

held at NANAIMO, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

STODGELL	Jason Christopher
SURNAME	GIVEN NAMES

INTRODUCTION

The inquest into the death of Jason Christopher Stodgell commenced at 0950 hours on May 15, 2007 at Nanaimo Court and continued on May 16 & 17, 2007. John Orr was coroner's counsel. Richard Meyer appeared on behalf of the Province of British Columbia as represented by the Ministry of Public Safety and Solicitor General. Deputy Sheriff Bruce Mowatt took charge of the jury and recorded the exhibits.

The following witnesses testified:

1. Dr. Charles Lee, Forensic Pathologist
2. Dr. Walter Martz, Forensic Toxicologist
3. Deputy Warden Jim May, Nanaimo Correctional Centre
4. Nikki Emerson
5. Cpl Rhonda Stoner
6. Cst S. Dimopoulos
7. S/O Stefan Nowosielski
8. S/O Stephen Stewart
9. Assistant Deputy Warden M. McLeod
10. S/O D. Lee
11. Art Cochrane, BC Ambulance Service
12. Dr. John Justin Grabher, Nanaimo Regional General Hospital
13. Warden Don Moody, Nanaimo Correctional Centre
14. Graham Currie
15. Assistant Deputy Warden Scott Vallance

The following exhibits were entered into evidence:

1. Registration of Death
2. Report of Post Mortem Examination
3. Toxicology Report
4. Book of 13 Photos
5. Client Form
6. BC Ambulance Crew Report
7. BC Ambulance Pre-Hospital Cardiac Arrest and Trauma Record
8. Curriculum Vitae, Dr. John Justin Grabher

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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.

Security Officer (S/O) Nowosielski described the routine in the dorm at the Nanaimo Correctional Centre where Mr. Stodgell resided. Prisoners are told by a public address system at 2300 hours to return to their dorms and the overhead lights are turned off. All TVs are shut off at 2330 hours. At 2400 hours, all inmates should have their personal bed space area lights off.

S/O Nowosielski was working the 1900 to 0200 hours shift on May 18th/19th, 2006 and had received no port at shift change regarding the presence of illicit drugs in the dorm.

At midnight, a formal count of the prisoners must be done confirming "hair, skin and breathing". Mr. Stodgell was in his bed space at midnight. At approximately 0050 or 0055 hours, S/O Nowosielski and S/O Stewart entered Dorm 4 where Mr. Stodgell slept to conduct a bed check. They each carried a flashlight which they shined in each individual bed area. When they arrived at Mr. Stodgell's bed unit, they found him on his right side with his head over the side of the bunk. He had vomited and did not appear to be conscious.

The officers entered the bed space and attempted to rouse Mr. Stodgell. He did not respond to shouts, shaking or pain stimulus applied by S/O Stewart. No pulse was felt and he did not appear to be breathing. He was warm and sweaty to the touch. S/O Nowosielski radioed the control centre that he had a Code Blue, a medical emergency.

Nikki Emerson, an inmate at the time of Mr. Stodgell's death, heard the officers trying to rouse Mr. Stodgell and approached to assist. Other inmates also gathered. Comments were made by the inmates that Mr. Stodgell was fine, that he was a heavy sleeper, and that they should let him sleep.

S/O Nowosielski and S/O Stewart started CPR. Mr. Emerson gave evidence that he tried to stop them because he felt a pulse but, at the time of the incident, he gave a statement to Nanaimo RCMP Cpl Rhonda Stoner in which he said he had not felt a pulse.

Assistant Deputy Warden McLeod, a Senior Correctional Officer (SCO) at the time, received the Code Blue alert at 0100 hours and arrived in Dorm 4 within 5-10 seconds. He noted CPR being done appropriately

and stood by. Correctional Officer (CO) Lee heard the Code Blue call and attended the dorm immediately. He assisted with crowd control and retrieved a pocket mask for S/O Stewart.

A call was made to ambulance dispatch from the Nanaimo Correctional Centre control centre and Advanced Care Paramedic Art Cochrane and his partner were dispatched at 0103 hours. They left the ambulance station at 0105 hours and arrived at 0109 hours. They were met by staff and waived through to the building where Mr. Stodgell's dorm was located. They loaded their equipment on a stretcher and arrived at Mr. Stodgell's bed space at 0110 hours.

Mr. Cochrane stated that tension was high in the dorm and there were a lot of people in the room, both staff and inmates. The bed space was too small to properly assess Mr. Stodgell and he was moved to the hallway. On assessment, he was unconscious with no pulse and no respirations. He was connected to an ıtomatic External Defribilator which assessed him and reported he was asystole, meaning no heart rhythm was detected.

Mr. Cochrane overheard inmates discussing the possibility of drug use and making suggestions as to how Mr. Stodgell should be treated. Inmates were saying Mr. Stodgell should be administered drugs such as Narcan to reverse the effects of any opiates. Mr. Cochrane explained that drugs are not effective unless blood is circulating and Mr. Stodgell's heart was not functioning on its own yet therefore the administration of drugs was not his first priority.

Mr. Stodgell was prepared for transfer to Nanaimo Regional General Hospital. An intravenous line was prepared in his left arm and he was removed by the paramedics at 1132 hours. SO Lee accompanied them to assist with chest compressions. En route to hospital, with CPR continuing, Mr. Stodgell was intubated to assist with breathing and administered drugs to stimulate his heart.

Dr. Grabher treated Mr. Stodgell on arrival at the Emergency Department. The ER team had been alerted to his arrival and were ready and waiting. Mr. Stodgell was not breathing without assistance. His heart was not beating and an ultrasound revealed no cardiac activity. His pupils were fixed and dilated indicating no brain function. He was pronounced dead shortly after arrival.

Dr. Grabher stated it takes only 4 minutes without oxygen before the brain starts to die. He described a 10 minute response time by ambulance as very appropriate and that first aid treatment in the event of ıy cardiac arrest is always to provide basic life support: airway, breathing and circulation.

It was Dr. Grabher's opinion that Mr. Stodgell would likely have had to have taken the drugs after midnight.

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

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Forensic Toxicologist Dr. Walter Martz reported significant levels of morphine and methadone in Mr. Stodgell's system. Morphine and methadone are drugs available by prescription and also used illicitly. Regular use of these drugs increases tolerance in the user. Interpretation of drug levels requires knowledge of the user's dosage and tolerance as therapeutic and lethal levels overlap. A level could be therapeutic for one person and lethal in a person with a lower tolerance. An individual's tolerance decreases in a matter of days without drugs. Intravenous administration has the quickest affect. Mr. Stodgell was not prescribed either of these drugs at the time of his death.

Dr. Charles Lee found no evidence of trauma, injury or disease to account for Mr. Stodgell's death. Based on the toxicology report and Mr. Stodgell's history of incarceration, Dr. Lee came to the conclusion that his tolerance to drugs would have decreased and his morphine and methadone levels could be interpreted as being lethal.

Deputy Warden Jim May gave evidence about access to drugs in prison. He stated 70 to 80% of the prison population has alcohol and/or drug dependency issues. He described the efforts Corrections BC staff make to prevent the entry of drugs into the prison including skin frisking; visitor pat downs and ion scanning; and, perimeter security using cameras and patrols. Deputy Warden May stated that inmates always find a way to get around efforts to prevent drugs from entering the facility. The Nanaimo Correctional Centre has a zero tolerance to drugs in the facility and Assistant Deputy Warden Scott Vallance expressed his opinion that the drug interdiction efforts are having a positive effect.

Evidence was heard that Mr. Stodgell had access to drug and alcohol treatment programs on several occasions and had recently expressed interest in returning to Maple Ridge for further treatment.

Inmates interviewed in relation to Mr. Stodgell's death reported that Mr. Stodgell had recently acquired an illicit supply of morphine and methadone and that he had been consuming it to excess the day before his death. Drug paraphernalia including a syringe was found in another inmate's bed area after Mr. Stodgell's death and Mr. Stodgell was noted to have venipuncture marks in his right arm.

Mr. Currie stated that Mr. Stodgell's drug of choice was heroin and that he had been advised about not using methadone in the same manner as it accumulated in the body. Mr. Currie stated that Mr. Stodgell had access to powdered methadone from outside the facility and that his route of administration was by injection.

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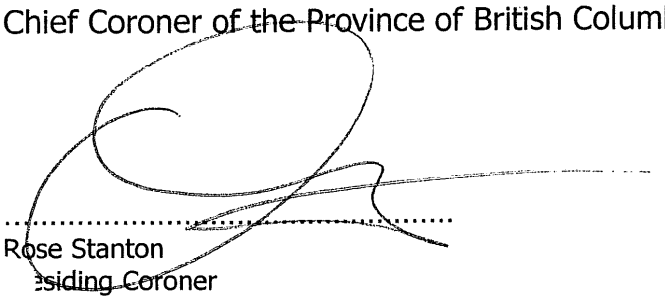
Deputy Warden Jim May described the many ways in which contraband including drugs and cell phones can enter a Correctional Centre and the efforts the centre takes to prevent this. It is not known by which method Mr. Stodgell obtained drugs.

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:



Rose Stanton
Presiding Coroner

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RECOMMENDATIONS OF THE JURY

To: Warden Don Moody
Nanaimo Correctional Centre
3945 Biggs Road
Bag 4000
Nanaimo, British Columbia V9R 5N3

1. To improve the visibility on the unit affected, when Code Blue is called, the lights should be illuminated.

2. To have an automatic defibrillator on site.

3. To include pocket masks as required equipment for staff to carry on their person at all times.

4. To continue with ongoing education for staff broadening the scope of crisis intervention to include role play and simulation.

5. To enforce the policies regarding securing the scene and crowd control.