BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No. 2007:0212:1085

An Inquest was held at Coroner's Courtroom, in the municipality of Burnaby

In the Province of British Columbia, on the following dates 19th, 20th and 21st November 2008

before Tonia Grace, Presiding Coroner,

Into the death of McKenna (Last Name,) Cecil Edward (First Name) 50 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: 27th October 2007 late hours

Place of Death: Surrey RCMP cells (Location) Surrey, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Acute methadone toxicity

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

The above verdict certified by the Jury on the 21st day of November AD, 2008.

TONIA GRACE

Presiding Coroner's Printed Name

POSTED

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO 2007:0212:1085

MCKENNA	CECIL EDWARD
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Tonia Grace

Coroner Counsel: Chris Godwin

Court Reporting/Recording Agency: Verbatim Words

Participants/Counsel: 1. the South Coast British Columbia Transportation Authority/Reece Harding
2. the Attorney General of Canada/ David Kwan
3. the City of Surrey/Anthony Capuccinello

The Sheriff took charge of the jury and recorded 19 exhibits. Seventeen witnesses were duly sworn in and testified. One witness statement was also read out (witness since deceased).

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 not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

Cecil Edward McKenna lived a homeless lifestyle. He had a long history of illicit drug abuse which centered primarily around heroin and cocaine use. He was a participant in the methadone program and had been for a number of years. He was prescribed a low dosage and had been taking this dosage since June 2007. He was required to take his dose witnessed in the pharmacy. He was not permitted to take it away with him. He had a history of seizure disorder.

On the afternoon of October 27, 2007, he had two encounters with the Surrey RCMP. Neither encounter resulted in arrest. On the first occasion, the BC Ambulance Service was called by the RCMP as Mr. McKenna appeared to be under the influence of a substance. BC Ambulance paramedics attended and assessed Mr. McKenna. It was determined on that occasion that he did not require medical attention. On the second occasion later that afternoon, Mr. McKenna did not appear to be under the influence of any substance and subsequently, the RCMP officers determined that he did not require any medical assessment.

At approximately 1910 hours (approximately 40 minutes after Mr. McKenna's second encounter with the Surrey RCMP), Mr. McKenna was arrested at the Surrey Centre Skytrain Station by Translink police officers, following a complaint of public intoxication from a member of the public. He was taken to Surrey RCMP detachment and lodged into cells. Mr. McKenna was compliant and able to walk. He was noted to be under the influence of drugs on the C13 booking form. Medical attention was not sought for him by the Transit police, the RCMP or cell guards as it was not considered necessary. At this time his personal belongings including medication for his seizure disorder was taken from him. A bottle was also taken from him that was later tested and found to contain traces of methadone. It is unknown where Mr. McKenna obtained this methadone.

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At approximately 2000 hours on October 27, 2007, Mr. McKenna entered the cell, lay down on the mattress provided and covered himself with a blanket. The last definite movement by Mr. McKenna, as seen on the video surveillance tape, was at 2207 hours that evening. He was subsequently checked by the cell guards every 15 minutes. This was done by looking through the small glass cell door window. Mr. McKenna was lying facing the wall with his back to this window.

Despite the requirement of both national and provincial RCMP policy to regularly assess the responsiveness of prisoners in accordance with the rousability chart, Mr. McKenna was not assessed for responsiveness/rousability at any point during his time in the cell.

When an RCMP officer entered the cell at 0613 hours on October 28, 2007 in order to release him from custody, Mr. McKenna was found deceased.

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Pursuant to Section 38 of the Coroner's 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: Chief Superintendent W.F. MacRae
Officer in Charge of Surrey Detachment
14355 – 57 Avenue
Surrey, BC V3X 1A9

We recommend that:

1. the following new procedure: "When dealing with intoxicated prisoners carrying properly labelled prescription medications, the RCMP MUST contact the prescribing physician or the poison control centre to authorize the administration of the said medication" be added to the current Standard Operating Procedures entitled "Prisoner Medication" found at pages 80-82 of Module D.

   Coroner's Comment: The jury heard evidence that there was no procedure in place for those who were intoxicated and in possession of medication so as to ensure that the medication was properly and appropriately administered while in custody.

2. there be a policy implemented to check rousability of intoxicated prisoners every two hours, rather than the current interim Surrey detachment measure of every four hours.

   Coroner's Comment: The jury heard evidence that the RCMP Surrey Detachment, since the death of Mr. McKenna and as a result of a death of another individual, now required that all prisoners be roused every four hours. The jury felt that this needed to be less for those who were intoxicated and therefore, more at risk.

To: Deputy Commissioner Gary D. Bass
Commanding Officer "E" Division
Royal Canadian Mounted Police
5255 Heather Street
Vancouver, BC V5Z 3L7

3. We recommend that there be a policy implemented to check rousability of intoxicated prisoners every two hours.

   Coroner's Comment: see above at number 2.

MCKENNA	CECIL EDWARD
SURNAME	GIVEN NAMES

To: Chief Superintendent W.F. MacRae
Officer in Charge of Surrey Detachment
14355 – 57 Avenue
Surrey, BC V3X 1A9

And

To: Mr. Murray Dunwoodie
City Manager
City of Surrey
14245 – 56th Avenue
Surrey, BC V3X 3A2

4. We recommend that every three months, a review of random cell block video recordings should be performed to monitor guard effectiveness and to ensure the proper attention to prisoners' wellbeing as referred to in National Policy 19.3, sub-section 2 "assessing responsiveness".

   Coroner's Comment: The guards gave evidence that they specifically checked to make sure each prisoner was breathing when doing their cell checks each time by closely watching through the cell door window and paying specific attention to the prisoner's chest to ensure it was moving up and down. The video evidence played did not support this.

To: Officer in Charge of BC Ambulance Service,
PO Box 9600, Stn Prov Govt
Victoria, BC V8W 9P1

5. We recommend that on-board computers be installed in all ambulances to provide capability for data input and to allow for immediate access to records of previous paramedic attendances.

   Coroner's Comment: The jury heard evidence that the BC Ambulance Service paramedics were unaware of the previous attendances/involvement of other paramedics with Mr. McKenna on the day of his death. This evidence highlighted the fact that there is currently no system in place which allows paramedics to access previous records on patients in order that they can be better informed about a patient when assessing and treating him or her.