BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2006:255:0052

An Inquest was held at Office of the Chief Coroner, in the municipality of Burnaby

in the Province of British Columbia, on the following dates October 7-8, 2008

before Owen Court, Presiding Coroner,

into the death of PETE Candice 22 ☐ Male ☒ Female
(Last Name, First Name) (Age)

and the following findings were made:

Date and Time of Death: January 9, 2006 at 2246 hours

Place of Death: ICU Ward at St. Paul's Hospital Vancouver, BC
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Multi-Organ Failure

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Acute Cocaine Intoxication

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 8th day of October AD, 2008.

OWEN COURT
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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

PETE	CANDICE
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Owen Court

Inquest Counsel: Steven Boorne

Court Recorder: Vivian Kariya, Verbatim Words West Ltd.

Counsel/Participants: Dawn Boblin – City of Vancouver
Keith Johnston – BC Corrections Branch

Deputy Sheriff Shelly Pachota took charge of the jury and recorded eight exhibits. 10 witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

On the morning of 5 January 2006, uniformed members of the Vancouver Police Department encountered Ms. Candice Pete on the streets of the Downtown Eastside. Ms. Pete was found to be in possession of illegal drugs and was arrested. She was transported to Vancouver Jail via police wagon, searched and booked into a cell.

Later that afternoon, while still incarcerated, Ms. Pete suffered a seizure. She was treated by Vancouver Jail nursing staff and paramedics from the BC Ambulance Service. Ms. Pete was released from custody and transported via ambulance to St. Paul's Hospital.

Ms. Pete was admitted to St. Paul's Hospital with a presumed diagnosis of cocaine intoxication and administered multiple medications to control seizure activity. Her condition rapidly deteriorated and she was placed on life support.

Ms. Pete's condition did not improve during her period of hospitalization. She was subsequently diagnosed with multi-system organ failure and a non-survivable brain injury. After discussion with her family members, the decision to withdraw care was made and Ms. Pete died on the evening of 9 January 2006.

Autopsy and toxicological analysis revealed that death occurred as a result of multi-organ failure, due to acute cocaine intoxication. It is presumed that Ms. Pete swallowed an amount of cocaine at or about the time of her arrest and that the drug released into her system a short time later, thereby setting into motion the sequence of events that ultimately led to her death.

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Pursuant to Section 38 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:

JURY RECOMMENDATIONS:

To: BC Corrections Branch
Ministry of Public Safety and Solicitor General

Presiding Coroner's Comments: The Jury heard evidence that the Vancouver Jail was under the control of the BC Corrections Branch at the time of Ms. Pete's death, but that management of the facility has since been assumed by the Vancouver Police Department. It is therefore suggested that the Jury's Recommendations also be forwarded to the Vancouver Police Department.

1. All live/working video cameras to be actively monitored by appropriate staff.

2. Ensure staffing levels are such that all monitors are viewed continuously.

Presiding Coroner's Comments: The Jury heard evidence that the Vancouver Jail utilizes approximately 180 video cameras for the monitoring of inmates and that images captured by cameras are displayed on one of nine monitors. The Jury also heard evidence that the images are not automatically rotated on the monitors, rather that they must be manually selected for viewing.

3. All emergency response kits to be checked for completeness at the beginning and end of each shift and that after each use, to be replenished immediately.

4. An appropriate delivery system to be attached to each medication.

Presiding Coroner's Comments: The Jury heard evidence that Vancouver Jail medical staff experienced difficulty in administering an injectable medication to Ms. Pete because the syringe available to them was too small in diameter.