BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2007:0568:0087

An Inquest was held at Penticton Trade & Convention Centre, in the municipality of Penticton

In the Province of British Columbia, on the following dates 27th – 29th May 2008 and 3rd June 2008

before Tonia Grace, Presiding Coroner,

into the death of Qualtier (Last Name) Steven (First Name) 46 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: 5th August 2007 at 1045 hours

Place of Death: Kelowna General Hospital (Location) Kelowna, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Cerebral edema

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Acute subdural hematoma

DUE TO OR AS A CONSEQUENCE OF

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

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 3rd day of June AD, 2008.

TONIA GRACE

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

FILE NO.2007: 0568:0087

QUALTIER	Steven
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Tonia Grace

Inquest Counsel: Steven Boorne

Court Reporting/Recording Agency: Vivian Kariya from Verbatim Words

Participants/Counsel: Sheilah Marsden (daughter)
Helen Roberts (Counsel for Attorney General of Canada)
David Pilley (Counsel for Dr. Gerald Partridge)

The Sheriff took charge of the jury and recorded sixteen exhibits. Eighteen witnesses were duly sworn in and testified.

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.

At approximately 1330 hours on August 4, 2007, Steven Qualtier was involved in an altercation in Keremeos during which he struck the first blow against an acquaintance called . Mr. Qualtier was then punched by Mr. , seemingly in self-defence, resulting in Mr. Qualtier falling backwards and hitting his head on the concrete sidewalk. He may have momentarily lost consciousness. Mr. Qualtier was heavily under the influence of alcohol at the time of the incident.

The local RCMP was called by a storekeeper and Sergeant Dickie attended the scene within minutes. He noticed an injury to the back of Mr. Qualtier's head and summoned the immediate assistance of the nearby BC Ambulance Service crew. Mr. Qualtier was subsequently taken to Keremeos treatment centre and seen by Dr. Partridge who was familiar with Mr. Qualtier. Dr. Partridge examined Mr. Qualtier in the presence of Sergeant Dickie and a BC Ambulance paramedic. Dr. Partridge subsequently advised Sergeant Dickie that Mr. Qualtier should not be left alone as the symptoms of head injuries took some time to develop and he therefore required close monitoring. No more specific instructions were given. No written instructions and/or information was given. As it was presumed by the physician and police officer that no-one would be available to monitor Mr. Qualtier, he was formally arrested and taken into custody by Sergeant Dickie who transported him to the Penticton detachment. Upon arrival, Mr. Qualtier was unable to walk to the cell and was dragged there by Sgt. Dickie and another officer.

During the booking-in procedure at the Penticton detachment, the evidence revealed there appeared to have been a significant breakdown in communication and/or disagreement in recollection. Sgt. Dickie stated he had told the cell matron, Jessica Ens, that Mr. Qualtier had been

In a fight, hit his head and required close monitoring, though he did not tell her why he required close monitoring. The cell matron, Jessica Ens, gave evidence that she was not told that that Mr. Qualtier had a head injury and was not given any special instructions about monitoring or otherwise. She had simply been told he had been in a fight and had been cleared by a physician. While Sgt Dickie had recorded the words "bump on back of head" on the prisoner report form known as the "C13", she stated she had not seen this form and was not required to review it.

Despite the existence of RCMP policy requiring constant monitoring of all prisoners who had been cleared by a physician as fit for incarceration, this was not done. Standard prisoner checks were done after he was searched at from 1520 hours to shortly before 2200 hours. Consistently all the witnesses including police officers and cell employees were either confused or unaware of the need to ensure that the responsiveness box on the C-13 was properly utilized. It had not been checked on Mr. Qualtier's form at any stage.

Just before 1800 hours, Constable Shaun Knowles came on duty. He was approached by the cell guard, Scott Strickland who had himself recently come on duty. Mr. Strickland stated he had expressed his concerns that Mr. Qualtier should not be in custody as he had been in a fight, had bumps on his head and in view of the fact that, a few days earlier, Mr. Qualtier had had a seizure in the cells and had to be taken to hospital. Cst. Knowles, a first aid instructor, shared his concerns but the watch commander, Corporal Stuart Falebrinza did not and told them both that as Mr. Qualtier had been cleared by a physician, he was staying in his cell. Cpl. Falebrinza gave evidence that during this conversation he approached the cell of Mr. Qualtier and kicked the door which provoked a response form Mr. Qualtier by way of a minor head movement. This door kick was not recollected by anyone else nor was any other attempt by Corporal Falebrinza to rouse Mr. Qualtier. Cpl. Falebrinza considered the action of him kicking at the cell door to be equivalent to a rousal of the prisoner, though he accepted it did not sit in accordance with policy found in the RCMP Operational Manual App. 19-2-1 entitled "Assessing Prisoner Rousability" and often referred to as the "4-Rs" chart. The cell guard, Scott Strickland also stated he himself banged the cell door some time after the conversation and was met with a minimal response at best. Review of the cell footage showed that Mr. Qualtier did not move position after 1520 hours when Jessica Ens had placed him on his side. Both the cell guard and the cell matron were unaware of the local detachment policy requiring all prisoners who were intoxicated and had not moved in a two-hour period to be physically roused by a RCMP member.

No-one entered the cell to do a responsiveness check on Mr. Qualtier until 2152 hours. At that time Sergeant Terry Jacklin, the nightshift watch commander, entered the cell and after getting no response to the standard pain stimulate test, he immediately summoned an ambulance. Mr. Qualtier was subsequently transported to Penticton Regional Hospital. Though he was still breathing, he was unresponsive and the attending physician, Dr. Trevor Connolly, gave evidence that his prognosis was immediately determinable as very poor. Mr. Qualtier had a Glasgow Coma Scale of four with the minimum score attainable being a three. A subsequent CT scan revealed he had an extensive subdural bleed and he was later transferred to Kelowna General Hospital for the opinion and review of a neurologist. At Kelowna, it was the opinion of the neurologist, Dr. Goplen that the bleed was so extensive that it was beyond medical help. Mr. Qualtier was later declared brain dead by Dr. Goplen (and another physician) at 1045 hours on August 5, 2007. While it remains unknown whether earlier treatment would have saved Mr. Qualtier, the medical evidence was that the earlier treatment is given the better the chances are for survival. It was also

established that persons who abuse alcohol are more likely than those who do not, to suffer serious brain bleeds following blows to the head. The toxicology tests on blood samples taken shortly after admission to the hospital showed Mr. Qualtier had a blood alcohol level of 0.16%. Dr. Connolly considered by way of rough back calculation that at the time of the incident, Mr. Qualtier's alcohol level was likely to have been in the region of 0.32-0.48%. He stated that a lethal level of alcohol poisoning itself could result from levels between 0.35 – 0.50%.

The evidence showed that the cell guard and matron (as well as most of the police members) were unaware of the need to closely monitor prisoners or the requirements about checking the responsiveness of prisoners. The training of the guards/matrons was minimal and infrequent. Policy was not well known nor well understood. It was applied infrequently and there were no steps taken with either the guards or members to ensure it was properly adhered to. Policy was viewed by most as simply guidelines, often without force, and with no consequences for failure to follow them unless the action was considered to be very serious. This latter fact was confirmed by the primary investigator from the major crimes unit who stated that the focus of his investigation was whether there had been any criminal wrongdoing and not to consider breach of policy unless there was something substantial.

The pathologist, Dr. Tebbutt-Speirs, gave evidence that the cause of death was cerebral edema caused by an acute subdural hematoma as a consequence of a closed head injury. The evidence at the start of the inquest had been that the closed head injury was caused by the intentional (i.e. non-accidental) use of force, that is a deliberate punch by Mr. Terbasket, albeit in self-defence.

After deliberation the jury classified the death of Steven Qualtier as homicide.

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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: Commanding Officer of Keremeos RCMP
Keremeos RCMP Detachment
PO Box 3402
Keremeos, BC V0X 1N0

To: Band Chief and Council of Lower Similkameen Indian Band
517-7 Avenue, Box 100, Keremeos, BC V0X 1N0

1. We recommend a person be appointed to mediate between the RCMP and the family of an intoxicated injured or arrested band member who has been placed in custody for public intoxication. This will ensure band members are not in custody of the RCMP when a responsible 3rd party is available.

This recommendation flowed from the evidence that Mr. Qualtier was only taken into police custody because there was no-one thought to be available to closely monitor him, though no specific enquiries had been made.

To: Commanding Officer of Keremeos RCMP
Keremeos RCMP Detachment
PO Box 3402
Keremeos, BC V0X 1N0

To: Commanding Officer of Penticton RCMP
Penticton RCMP Detachment
1168 Main Street
Penticton, BC V2A 5E8

2. We recommend where there is no alternative but to transport an intoxicated and/or injured person to cells under a physician's release, any instructions for care or observations by the doctor should be noted by the member on a written form in the doctor's presence. This form should be attached to the C-13 booking form. It should be read and initialed by the guard and watch commander upon booking-in and by oncoming staff.

This recommendation flowed from the evidence that nothing was obtained in writing from the physician setting out his instructions or observations and no notes were made on the C-13 form by the RCMP officer who booked him in. A local form did exist that was utilized at a local level when a prisoner had been taken from cells to a physician and returned then returned to the cells but was not used for prisoners who had seen a physician prior to being brought to cells. The evident was that the use of a form attached to the C-13 would have been a useful and evident visual indicator to those dealing with a prisoner that he/she had medical issues.

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To: Commanding Officer of Penticton RCMP
Penticton RCMP Detachment
1168 Main Street
Penticton, BC V2A 5E8

We recommend:

3. All personnel on shift responsible for the care of prisoners must fully read and understand the information contained on each prisoner's C-13 form. Space should be provided at the bottom of the C-13 form to record the initials of said personnel and the time of so doing, thereby indicating that they have read and understood the contents of the form.

This recommendation flowed from the evidence that the cell matron, cell guard and RCMP supervisors did not ordinarily review all the information on the C-13 form, thereby meaning pertinent facts recorded on the same would not always be known by personnel responsible for the care of prisoners.

4. Copies of all relevant RCMP policy manuals should be given to all guards and members. Any revision or changes to policy should be initialed by guards and members after having read them. Copies of these changes should be provided to guards and members. Semi-annual retraining should include a review of the manuals to ensure consistency in the implementation of policy. Guards and members attending review, training, retraining, or attending meetings regarding policy should initial a form that documents the time, date and place of such professional development. This form should be kept on file.

This recommendation flowed from the evidence that guards/matrons were not provided with their own manual neither during training or thereafter. One copy of the relevant manual was kept at the police detachment. Semi-annual training may or may not include review of policy and evidence was that it was somewhat ad hoc and not recorded.

5. Policy regarding responsiveness and rousability should not be considered guidelines and should be strictly adhered to.

This recommendation flowed from the evidence the RCMP policy already in existence regarding responsiveness and rousability was not routinely followed and was viewed loosely by many of the officers and the cell employees and seen as not something that needed to be properly followed but could be flexibly interpreted or even ignored.