BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2007:1001:0026

An Inquest was held at Western Communities Courthouse, in the municipality of Colwood

in the Province of British Columbia, on the following dates January 30 and 31, 2008 and February 1, 2008

before Marj Paonessa, Presiding Coroner,

into the death of Wayne Allan TURNER (Last Name, First Name) 31 years (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: 22 February, 2007 at Time: 1933 hours

Place of Death: VIRCC, 4216 Wilkinson Road, (Location) Victoria (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Asphyxiation

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) hanging.

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 1st day of February, AD, 2008.

MARJ PAONESSA

Presiding Coroner's Printed Name

Paonessa

Presiding Coroner's Signature

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

FILE NO.: 2007:1001:0026

Wayne Allan	TURNER
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST

Presiding Coroner: Marj Paonessa

Coroner Counsel: John Orr

Court Reporting/Recording Agency: Verbatim Words West

Participants/Counsel: B.C. Corrections Branch represented by Mr. Tim Leadem and Calibre Health Services represented by Ms. Karen Carteri.

The Sheriff took charge of the jury and recorded 15 exhibits. Twenty 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.

The Jury heard evidence that Wayne Allan Turner was a 31 year old inmate at Vancouver Island Regional Correctional Centre (VIRCC) in Victoria. Mr. Turner arrived at VIRCC on February 14, 2007, and underwent an institutional risk assessment on arrival by a Classification Officer whose responsibility it is to determine the inmate's placement within the institution. The inmate's current physical health, incompatibility with other inmates, court ordered 'no contacts' and mental health status are all taken into consideration. The Classification Officer had access to the computerized master file on Mr. Turner and stated there was no previous suicidal behaviour noted on the computer. Mr. Turner had admitted that he was withdrawing from recent illicit drug use (heroin, cocaine and Ecstasy) and that he had tried to stab himself in the leg the evening prior with a fork. He was tearful and agitated.

Mr. Turner was also seen by a Registered Nurse on intake for his initial health assessment. She reviewed a lengthy list of potential health issues with him. Mr. Turner also told her of his recent illicit drug use and that he had thoughts of self harm due to problems in his relationship. It was determined that Mr. Turner should be placed on 15 minute checks in the Segregation Unit for his own protection. Mr. Turner was later assessed by one of the contracted psychologists to VIRCC who supported the decision to place him on 15 minute watch due to his recent self harm. He had regular contact with the psychologists during his incarceration.

Inmates in the Segregation Unit are individually housed in cells that have a window in the door and

another overlooking the sink and toilet. They are allowed a half hour outside the cell twice a day to exercise, shower, get some fresh air in a separate court yard, or to use the phone. Mr. Turner was noted to use most of his time using the telephone to call his girlfriend.

On the afternoon of February 16, 2007, a 'Code Yellow' (officer needing assistance) was initiated by a corrections officer who had attended Mr. Turner's cell in response to Mr. Turner attempting to destroy his mattress cover and bedding and had threatened self harm. When the officer entered the cell, Mr. Turner punched him in the chest and the officer called for assistance. Mr. Turner was restrained with difficulty after the other officers arrived and he was treated by one of the nurses with an ice bag for a superficial injury over his left eye and his right jaw. He was institutionally charged with assaulting an officer and uttering threats to one of the psychologists for keeping him on 15 minute checks. Mr. Turner remained in Segregation and on 15 minute checks as a result of this offence.

On the morning of February 22, 2007, a different psychologist visited Mr. Turner. He described Mr. Turner as alert, oriented with organized thoughts and making good eye contact. His mood seemed to be positive. He had been eating regularly and there were no reports of self harm in the past two days. Mr. Turner talked about the possibility of returning to the general population unit so he could be with his friends. He said he was still feeling angry and threatening toward the other psychologist because he felt put down by him and that he did not listen to him. Mr. Turner denied any thoughts of self harm and asked to see this psychologist again the following day for assistance in resolving his anger management. The psychologist agreed to come back and visit with him again. Mr. Turner did not mention any relationship difficulties. The psychologist felt he was future oriented and took Mr. Turner off the 15 minute checks. He was to be checked every 30 minutes. This information was shared with the staff.

Mr. Turner was observed throughout the rest of the day on regular 30 minute checks. At approximately 1855 hours, an officer looked into his cell and observed Mr. Turner with a bedsheet ligature looped around his neck that had been fastened around a sprinkler head just inside the door. Mr. Turner's feet were on the floor, his knees were bent and he was leaning forward into the bedsheet. Assistance was immediately summoned and Mr. Turner's cell was entered. The bedsheet was cut and Mr. Turner was lowered to the ground where resuscitative efforts began by officers and nursing staff. Advanced life support paramedics arrived shortly thereafter, however despite all efforts, Mr. Turner could not be resuscitated. Death was pronounced after contact with a local emergency room physician at 1933 hours.

The postmortem examination did not identify any significant natural disease to have caused or accelerated death. The pathologist reported that toxicology studies were negative for alcohol, illicit drugs and medication. Mr. Turner's death was attributed to asphyxiation due to hanging. The pathologist testified that it takes very little pressure on the neck to obstruct blood flow and oxygen supply to the brain causing unconsciousness within a matter of seconds. Once unconscious, there is no chance for self rescue and the individual becomes brain dead within a matter of minutes.

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Wayne Allan	TURNER

Mr. Turner's family and girlfriend testified that Mr. Turner had a lengthy history of attention seeking behaviour. They were aware that he had verbally threatened to harm himself in the past but they never felt he was serious enough to go through with it. He was upset about his pending incarceration and how that would affect his relationship. However, his girlfriend testified she did not feel that he would seriously attempt to end his own life after their last conversation which took place approximately an hour and a half prior to his being discovered unresponsive. An inmate who was painting the hallway in the Segregation Unit that day also testified that he knew Mr. Turner well and did not observe any abnormal or distressing behaviour on the his part to indicate he would injure himself.

At the end of their deliberations, the Jury classified the death as accidental and put forward the following recommendations.

M Paonessa

Marj Paonessa
Presiding Coroner

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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: Mr. Brent Merchant
Provincial Director, Adult Custody Division
BC Corrections Branch
Ministry of Public Safety and Solicitor General
7th Floor, 1001 Douglas Street
Victoria, BC V8W 9J7

1. To ensure a qualified sprinkler technician inspects institutional sprinkler heads no less than once a year. Said inspection is to ensure the integrity of sprinkler heads have not been compromised and cannot be used as ligature points.

   Background Information

   The Jury heard evidence that the sprinkler head in Mr. Turner's cell may not have been secured tightly to the ceiling allowing for space between base rim and the steel ceiling. This could have been due to the heads themselves not being affixed tightly to the hanger rods that are on the other side of the ceiling.

2. Add a clause to the Adult Custody Policy which would be 9.13.9.4: "When an inmate is placed on 15 minute self harm watch, they are to be issued suicide prevention gown and blanket."

   Background Information

   The Jury heard that the institution has available blankets and gowns that are made of non-tearable material. These are provided to inmates considered to be suicidal.

3. When recorded phone calls or any other form of recorded communication are required for investigative and/or court purposes, a complete transcription shall be done by a qualified, external transcription agency.

   Background Information

   The Jury was told that inmate telephone conversations are recorded but not monitored. Based on her notes taken while she listened to the recordings after the fact, a Corrections Branch

officer gave evidence to the Jury about the general content of Mr. Turner's conversations with his girlfriend during the week leading up to his death.

4. When an incident is going to a coroner's inquest, documentation pertaining to the inmate(s) involved is to be consolidated into one document and put into chronological order. This includes all logs, shift reports and medical information.

5. A detailed scale drawing showing all areas germane to the investigation be provided.

Background Information

The witnesses that gave evidence at this inquest were not presented in a chronological order (pathologist evidence was provided first). The Jury did not receive the entire Corrections file related to Mr. Turner but was provided with the corresponding exhibits as they related to each witness' evidence. It did not become apparent until the end of the evidence that the plan drawing of the Segregation Unit did not include the observation cells and the nurses station.

To: Warden Dina Green
Vancouver Island Regional Correctional Centre
4216 Wilkinson Road
Victoria, BC V8W 9J1

6. Camera placement within Segregation/Observation Units be reviewed by a qualified external agency.