



VERDICT AT CORONER'S INQUEST

File No.: 2008-0366-0058

An Inquest was held at the Coroners Court, in the municipality of Burnaby in the Province of British Columbia, on the following dates February 10,11,12,13, 2009 before Owen Court, Presiding Coroner, into the death of Laura Eileen Coward 26 Male Female (Age) and the following findings were made:

Date and Time of Death: February 4, 2008, 0918 hours

Place of Death: Cell 6 RCMP Detachment 4592 Airport Rd Chilliwack, BC (Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Sudden Cardiac Arrest of Undetermined Cause 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

13th day of February AD, 2009

OWEN COURT

Presiding Coroner's Printed Name

Presiding Coroner's Signature



VERDICT AT CORONER'S INQUEST

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

FILE No.: 2008-0366-0058

COWARD

SURNAME

Laura Eileen

GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Owen Court
Inquest Counsel: Steven Boorne
Court Recorder: Vivian Kariya, Verbatim Words
Participants/Counsel: Reece Harding, counsel for the City of Chilliwack
Graham Stark, counsel for the RCMP
Sharleen Guilbault, mother of Laura Coward

The Sheriff took charge of the jury and recorded 17 exhibits. Seventeen witnesses were duly sworn and testified.

PRESIDING CORONER'S SUMMARY:

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 Friday, 1 February 2008, uniformed members of the Chilliwack RCMP arrested Ms. Laura Coward on outstanding warrants. Upon her arrest, Ms. Coward injected herself with a substance which she indicated was a prescribed pain medication. She was transported to the Chilliwack RCMP Detachment, searched and booked into a cell.

Because she had injected a drug upon her arrest, paramedics were called to examine Ms. Coward upon her admission to the cell block. Upon examination, Ms. Coward advised paramedics she had injected herself with oxycodone as she knew she would be in custody for a substantial period of time. Paramedics found her vital signs stable, treated her for a staph infection, advised police that she should be hospitalized if her level of consciousness were to decrease and left the cell block.

Later that evening, a senior RCMP member conducted his rounds of the cell block and found Ms. Coward in what he deemed to be a decreased level of consciousness. He called paramedics, who attended, examined her and formed the opinion that she should be taken to hospital for examination by a physician.

Ms. Coward was transported to a local hospital under RCMP guard. She was seen by an emergency physician, who found her responsive, treated her for open sores, indicated that she should be returned to hospital two days later for follow-up treatment and discharged her. She was transported back to the RCMP cell block, and upon her re-admission, the escorting officer wrote on Ms. Coward's C-13 (RCMP prisoner information form) that Ms. Coward was to be returned to hospital on Sunday, 3 February 2008 to have her dressings changed.

Ms. Coward was not taken back to hospital as recommended by the physician. She was housed in the RCMP cell block and according to video footage, Ms. Coward vomited or appeared to vomit numerous times over the following two days. She was found deceased in her cell the morning of Monday, February 4, 2008.

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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: Commissioner William Elliot
Royal Canadian Mounted Police
Headquarters Building
1200 Vanier Parkway
Ottawa ON K1A 0R2**

1. Recommend all RCMP members and guards receive a mandatory annual refresher course with a written exam of National, Divisional and Detachment policies with regard to cell block security, guarding prisoners, assessing responsiveness and medical assistance, and that records must be kept on file

Coroner's Comments: The Jury heard evidence that the interpretation and application of the three levels of RCMP policy can be challenging for both police officers and civilian employees.

2. Recommend that there be regular audits of RCMP procedures regarding cellblock security, guarding prisoners, assessing responsiveness and medical assistance

Coroner's Comments: The Jury heard evidence that RCMP policy requiring Watch Commanders to tour cell blocks and check the wellbeing of prisoners is not followed on a consistent basis.

3. Recommend that upon admission to cells, there be an immediate medical assessment of known or suspected substance abusers with re-assessment every 24-36 hours or as recommended by a medical professional

Coroner's Comments: The Jury heard evidence that individuals experiencing drug withdrawal require medical attention.

4. Recommend that under National Policy 19.2.2.1, the definition of illness be more specific

5. Recommend that guard training include both theoretical and practical (on the job) training regarding all levels of policy pertaining to cell block duties

Coroner's Comments: The Jury heard evidence that cell block policy is not consistently followed by guards and that guards would benefit from additional training.

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**TO: Officer-in-Charge, Chilliwack Detachment
Royal Canadian Mounted Police
45924 Airport Road
Chilliwack BC V2P 1A2**

6. Recommend that there be a physical check sign-off sheet utilized by both guards and RCMP members posted outside of each cell for the purposes of:
 - a. Signing all physical and responsiveness checks
 - b. Medical requirements and attentions received
 - c. Must be kept as part of the inmate's file upon release
7. Recommend that at guard shift change guards be required to do a physical cell check together and review C-13 forms, incident reports and medical requirements for each prisoner
8. Recommend that Watch Commanders or designates at shift change be required to do a physical cell check together and review C-13 forms, incident reports and medical requirements for each prisoner
9. Recommend that RCMP members complete fingerprinting duties in a more timely manner

Coroner's Comments: The Jury heard evidence that RCMP members do not always fingerprint prisoners upon their admission to the cell block and that prisoners not fingerprinted upon admission are subsequently fingerprinted on Monday mornings, prior to Court appearances.

10. Recommend that guards no longer perform clerical duties for prisoner transfer and release

Coroner's Comments: The Jury heard evidence that guards are regularly assigned clerical duties and that the performance of such duties interfere with their responsibilities to monitor prisoners.

**TO: City Manager, City of Chilliwack
8550 Young Road
Chilliwack BC V2P 8A4**

11. Recommend that guards have a shift overlap for peak periods. For example, Monday mornings, in order to prepare prisoners for court. A two hour period of overlap would seem reasonable

Coroner's Comments: The Jury heard evidence that there is substantial activity in the Chilliwack cell block on Monday mornings and that as a result, guards are often distracted from their normal duties.

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**TO: Honourable George Abbott
Minister of Health Services
Government of British Columbia
PO Box 9050
STN PROV GOVT
Victoria, BC**

12. We recommend that drug treatment be more accessible

Coroner's Comments: The Jury heard evidence that drug treatment facilities are not readily available in the Chilliwack area.

13. Recommend that treatment for substance abuse be available for incarcerated prisoners

Coroner's Comments: The Jury heard evidence that individuals experiencing drug withdrawal are often incarcerated in police cells over weekends and that such individuals would benefit from formal substance abuse treatment.

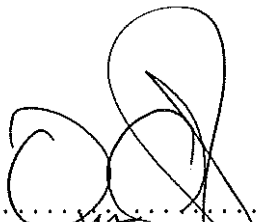
14. Recommend that ambulance crew reports be completed and available in a timely manner

Coroner's Comments: The Jury heard evidence that EHS Crew Reports are not always completed in time for review by emergency physicians and that the reports may contain information which would be useful to emergency physicians when assessing patients.

**TO: Registrar, College of Physicians and Surgeons of British Columbia
400 – 858 Beatty Street
Vancouver, BC**

15. Recommend that EHS crew reports be reviewed by emergency physicians prior to patient examination

Coroner's Comments: The Jury heard evidence that information contained in EHS Crew Reports may be useful to emergency physicians when assessing patients.



Owen Court
Regional Coroner, Province of British Columbia