



VERDICT AT CORONER'S INQUEST

File No.: 2008:0144:0044

An Inquest was held at Port Hardy Courthouse, in the municipality of Port Hardy in the Province of British Columbia, on the following dates May 19, May 20, May 21, 2009 before Shane DeMeyer, Presiding Coroner, into the death of PREVOST Albert William, 43, Male, and the following findings were made:

Date and Time of Death: 1810 hours, March 23, 2008
Place of Death: Campbell River and District Hospital, Campbell River/British Columbia

Medical Cause of Death

(1) Immediate Cause of Death: a) Extensive bilateral pneumonia
DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Ischemic stroke
DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Cocaine use

(2) Other Significant Conditions Contributing to Death:

Classification of Death: [X] Accidental [] Homicide [] Natural [] Suicide [] Undetermined

The above verdict certified by the Jury on the 21st day of May AD, 2009.

SHANE DEMEYER
Presiding Coroner's Printed Name

[Handwritten Signature]
Presiding Coroner's Signature



VERDICT AT CORONER'S INQUEST

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

FILE No.: 2008:0144:0044

PREVOST
SURNAME

Albert William
GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Shane DeMeyer

Inquest Counsel: John Orr

Court Reporting/Recording Agency: Pat Jane, Verbatim Words West

Participants/Counsel: Department of Justice, David Kwan

The Sheriff took charge of the jury and recorded 2 exhibits. 16 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.

At approximately 1800 hours on March 13, 2008, the Port Hardy Detachment of the Royal Canadian Mounted Police (RCMP) received a call involving a man who was reportedly intoxicated in public. Upon arrival, the RCMP members found Mr. Albert Prevost appeared intoxicated and had several medications including Tylenol 3 and Amitriptyline in his possession. Mr. Prevost was arrested for being drunk in a public place and was transported to the RCMP Detachment.

The RCMP members testified that he was taken into custody for his own safety. Port Hardy does not have shelter beds for persons who are intoxicated so the RCMP Detachment has become the de facto care placement. It was estimated that the RCMP Detachment houses between 900 and 1000 persons annually.

Mr. Prevost was placed in cells where he could be monitored. He was described as being agitated, but not aggressive. He demonstrated a lack of balance and was noted to be drooling. Another person incarcerated in the cell stated that Mr. Prevost had been rocking back and forth before going to sleep.

On the morning of March 14, 2008, RCMP members observed Mr. Prevost as he attempted to fold up his blanket and walk in the hallway. They stated they were concerned that it appeared he hadn't sobered after his stay in cells so they called the British Columbia Ambulance Service (BCAS).

BCAS staff attended the Detachment and made the decision to transport Mr. Prevost to the local hospital for further evaluation. As the Port Hardy Hospital does not have C.T. Scan capability, the decision was made to observe Mr. Prevost to see if he begins to recover from what appeared to be an intoxicated state.



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When it was evident that Mr. Prevost was not improving, he was transferred to Campbell River and District General Hospital. A C.T. Scan was completed that indicated Mr. Prevost had suffered an ischemic stroke and had suffered irreparable brain damage. On March 23, 2008, Mr. Prevost died in hospital from bilateral pneumonia as a consequence of the stroke and subsequent brain injury. Post mortem study concluded the ischemic stroke was likely due to the use of cocaine and that there would not have been any treatment options available.



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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:

Deputy Commissioner Gary Bass
Royal Canadian Mounted Police, "E" Division
657 West 37th Avenue
Vancouver, British Columbia
V5Z 1K6

1. To encourage the training of more Royal Canadian Mounted Police in the "Drug Recognition Course".

Howard Waldner,
Chief Executive Officer
Victoria Island Health Authority
Victoria, British Columbia

Minister of Health Services
Ministry of Health Services
1515 Blanshard Street
Victoria, British Columbia

2. That C.T. Scan equipment be made available at Port Hardy Hospital to service the Northern Island Region.

Minister of Health Services
Ministry of Health Services
1515 Blanshard Street
Victoria, British Columbia

Bill Blackman
Divisional Commander
Salvation Army
#103-3833 Henning Drive
Burnaby, British Columbia



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Howard Waldner,
Chief Executive Officer
Victoria Island Health Authority
Victoria, British Columbia

Minister of Housing and Social Development
Ministry of Housing and Social Development
PO Box 9058
STN PROV GOVT
Victoria, British Columbia
V8W 9E1

3. That shelter beds be available 365 days a year in Port Hardy.

Chief Coroner
B.C. Coroners Service
Metrotower II, Suite 800-4720 Kingsway
Burnaby, British Columbia
V5H 4N2

4. To provide a copy of the recommendations to:

Claire Trevena M.L.A.
John Duncan M.P.