BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2008:225:0707

An Inquest was held at Coroner's Courtroom, in the municipality of Burnaby

in the Province of British Columbia, on the following dates April 28-29, 2009

before Marj Paonessa, Presiding Coroner,

into the death of WAGEMANS Ryan Alexander 24 ☒ Male ☐ Female
(Last Name, First Name) (Age)

and the following findings were made:

Date and Time of Death: July 1, 2008 1:19 p.m.

Place of Death: Surrey Memorial Hospital ICU Surrey, BC
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Anoxic brain injury

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Cardiac arrest

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Acute methamphetamine intoxication.

(2) Other Significant Conditions Contributing to Death: Struggle that involved restraint.

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

The above verdict certified by the Jury on the 29 th day of April AD, 2009.

MARJ PAONESSA
Presiding Coroner's Printed Name

M Paonessa
Presiding Coroner's Signature

POSTED

WAGEMANS	Ryan Alexander
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Marj Paonessa

Inquest Counsel: Steven Boorne

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: Attorney General of Canada representing RCMP – Mr. Graham Stark
Translink – Mr. Christopher Martin

The Sheriff took charge of the jury and recorded four exhibits. Eleven 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 1800 hours on June 27, 2008, Mr. Wagemans boarded a Coast Mountain bus in Surrey at the Newton Exchange. The bus driver described him as being in an agitated state, pacing up and down the aisle and looking out all the windows. Mr. Wagemans was breathing heavily and appeared disoriented, but he was not threatening anyone. Shortly after the driver pulled away from the curb, Mr. Wagemans approached him and said he needed to get off. The driver pulled over at the next stop and opened the bus door. Mr. Wagemans walked to the bottom of the steps and leaned out looking both ways down the street. He told the driver that if he got off the bus, he would die and he retreated to the back of the bus. At this time, the driver pushed the emergency communication button which initiated a call back from dispatch. He advised them that he had a disturbed man on the bus and two security officers were dispatched to the next bus stop at 134th Street and 72nd Avenue.

The driver stopped at the bus stop and opened the door to await the arrival of the security officers. Mr. Wagemans continued to change seats and look out the windows. At one point he approached the driver and asked if the parked bus could go any faster. The security officers arrived and signaled Mr. Wagemans to step off the bus which he did. He appeared to be anxious and asked the officers to arrest him. He turned around and put his hands behind his back as if to be handcuffed. One of the officers got on the bus to speak to the driver while the other officer attempted to settle Mr. Wagemans by taking his arm and asking him to take a seat on the bench. Mr. Wagemans became combative and refused his commands. The two officers tried to put him down on the sidewalk between the bus and the bench. Mr. Wagemans had tremendous strength and they were unable to control his arms in order to handcuff him. The officers told the jury that Mr. Wagemans was kicking and trying to bite at them. The bus driver called dispatch to request the Surrey RCMP.

Suddenly, Mr. Wagemans stopped moving and the security officers observed amber coloured fluid flowing from his mouth. They immediately put him in a recovery position and checked for a pulse. The bus driver was asked to call for an ambulance. At this point, both officers testified that moments later Mr. Wagemans began to struggle with them again.

Two Surrey RCMP uniformed officers arrived and, with the assistance of the security officers, were successful in placing Mr. Wageman's wrists in cuffs. He was observed to become unresponsive again. More amber fluid was seen coming from his mouth. His airway was cleared by one of the officers and he was again placed in the recovery position. Surrey Fire Department and BC Ambulance Basic and Advanced Life Support (ALS) crews arrived on scene and determined that Mr. Wagemans was in full arrest and not breathing. Chest compressions were initiated, he was intubated and transported to Surrey Memorial Hospital. Mr. Wagemans did not regain consciousness and remained in the Intensive Care Unit until his death on July 1, 2009.

The postmortem and toxicology examinations confirmed the absence of any significant injuries and the presence of a lethal level of methamphetamine. No other drugs or alcohol were detected in Mr. Wageman's system upon admission to hospital. The pathologist testified that the added stressor of attempted restraint on an individual under the influence of methamphetamine can contribute to a cardiac collapse. If the blood is not circulated to the brain and other organs within a very short period of time, the individual suffers an anoxic brain injury which ultimately leads to brain death. In Mr. Wageman's case, he was not able to state with any certainty whether the outcome would have been different had medical assistance been summoned earlier.

After their deliberations, the jury classified this death as accidental and put forward the following recommendations to the Office of the Chief Coroner for dissemination.

Marj Paonessa
Presiding Coroner

WAGEMANS	Ryan Alexander
SURNAME	GIVEN NAMES

Pursuant to Section 16 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.

RECOMMENDATIONS

To: Mr. Denis Clements
President and CEO
Coast Mountain Bus Company
13401 – 108th Avenue
Surrey, BC V3T 5T4

1. All Transit Security Officers be certified in standard first aid with CPR for all age groups.

2. Bus operators have the opportunity to receive training in first aid.

   Background Information

   The Jury heard evidence that the security officers employed by Coast Mountain Bus Company do not receive first aid training in preparation for their employment. The security officers both testified that they felt this training would be of great assistance to them as they are often the first response to a wide variety of calls, some of which are medical in nature.

3. Create a confidential code protocol for drivers and security to notify telecommunications to provide a quick response from appropriate agencies.

   Eg. 1 = Security
   2 = Police and security
   3 = Security and ambulance

   Codes can be used in combination.

   Background Information

   The jury heard evidence that the bus driver presses an emergency button once which initiates a call back from dispatch. The bus driver advises the operator of the nature of the situation and the appropriate agency (security officer, police, ambulance) is dispatched to their location. This recommendation would suggest that a code system be incorporated into the system to expedite the initiation of specific responders.

To: Sue Conroy
Chief Operating Officer
B.C. Ambulance Service
Block B, 2261 Keating Cross Road
Saanichton, BC V8M 2A5

4. Increase the number of ALS ambulances to one per hospital.

   Background Information

   The jury heard evidence that ALS crews receive specialized advanced training and only respond to high priority calls, such as cardiac arrests and significant trauma injury situations. An ALS crew is assigned to a district or area and may have priority calls backing up as they transfer patient care to emergency physicians in the hospitals within their area.

5. Ambulance attendants carry digital voice recorders to facilitate the transcription of data quickly, efficiently and accurately.

   Background Information

   There was evidence that the timeline on one of the crew reports was filled out in error as the paramedic filled out the report after the fact while responding to another call.