Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2008:0217:0158

An Inquest was held at the Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates September 8 - 10, 2010

before Madam Tonia Grace, Presiding Coroner,

into the death of WALKER, Scott Alexander (Last Name, First Name Middle Name) 43 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: February 7, 2008 @ 1430

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

Medical Cause of Death

(1) Immediate Cause of Death: a) Liver failure

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Hepatic cirrhosis

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Hepatitis C infection and chronic alcoholism

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 10 day of September AD, 2010.

Tonia Grace
Presiding Coroner's Printed Name

Presiding Coroner's Signature

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Tonia Grace

Inquest Counsel: Rodrick MacKenzie

Court Reporting/Recording Agency: Verbatim Words

Participants/Counsel:
1. the Attorney General of Canada/David Kwan
2. the City of Surrey/Anthony Capuccinello

The Sheriff took charge of the jury and recorded thirteen exhibits. Sixteen 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.

Scott Alexander Walker had a long history of chronic alcohol use. He was also a participant in the methadone program and had been for a number of years. His problem with alcohol had led to a number of encounters with law enforcement and on a number of occasions, he had been seen to drink mouthwash from a bottle straight off the shelf in stores.

At approximately 1530 hours on February 3, 2008, Mr. Walker was detained by a loss prevention officer at a Safeway store in Surrey for stealing a bottle of mouthwash. Prior to the arrival of the Surrey RCMP, Mr. Walker consumed some of the mouthwash (which contained alcohol). Following the arrival of the police officer, Mr. Walker complained of feeling unwell. BC Ambulance paramedics attended and determined he was fit for incarceration. They wrote on their crew report form that Mr. Walker had a history of seizures.

Mr. Walker was later taken to the Surrey detachment and placed into cells at 1724 hours. He was detained for court as he was in breach of an undertaking not to consume alcoholic products imposed following his arrest in Delta for theft of mouthwash the previous day.

Review of CCTV cell footage revealed that at approximately 0432 hours on February 4, 2008 and then again at 0434 hours, he appeared to have a seizure. At 0539 hours, he told a guard that he thought he was going to have a seizure and she recommended that he place his sleeping mat on the floor in order that he could be more closely monitored and in order to avoid injury from falling off the raised sleeping platform. The evidence revealed that no guard closely had monitored Mr. Walker thereafter via CCTV. At 0557 hours Mr. Walker went to the cell door to talk to the guard and had an apparent seizure in front of the guard.

BC Ambulance was called and Mr. Walker had another couple of seizures. He was transported to Surrey Memorial Hospital where he had more seizures. A diagnosis of alcohol related withdrawal

seizures with hallucinations (i.e. delirium tremens) was made. Despite treatment, he went into chronic liver failure and later died at 1430 hours on February 7, 2008. The cause of death was found to be liver failure due to hepatic cirrhosis due to chronic alcoholism and hepatitis C infection. The pathologist gave evidence that the trigger for this condition to progress to being fatal can be as a result of external event/s.

The evidence showed that the cell guards, police officers and BC paramedics involved were unaware at the time that a chronic alcoholic is at risk of alcohol withdrawal seizures when he is unable to consume alcohol and this is a serious life threatening situation which can often be fatal. They were now aware of this as a result of this case.

VERDICT AT INQUEST

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

FILE NO.:2008:0217:0158

WALKER	Scott Alexander
SURNAME	GIVEN NAMES

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: Deputy Commissioner Gary Bass
Commanding Officer of "E" Division
Royal Canadian Mounted Police
5255 Heather Street
Vancouver BC V5Z 3L7

To: Honourable Michael de Jong
Solicitor-General of BC
PO Box 9053, Stn Prov Govt
Victoria, BC V8W 9E2

We recommend that:

1. The RCMP and Municipal Forces share a database of information to help aid jurisdiction issues.

Coroner's Comment: The jury heard evidence that there was no current system in place to allow RCMP and Municipal forces to be made aware of previous encounters each have had with the same individual. In this case, the example related to Delta Police department and Surrey RCMP department.

To: Deputy Commissioner Gary Bass
Commanding Officer of "E" Division
Royal Canadian Mounted Police
5255 Heather Street
Vancouver BC V5Z 3L7

To: Chief Superintendent Fraser MacRae
Surrey RCMP detachment
14355 – 57th Avenue
Surrey, BC V3X 1A9

We recommend that:

2. The C-13 form be updated in the system to best reflect medications and health issues. There should also be a date on the C-13 form showing when the information was last updated.

Coroner's Comment: The jury heard evidence that the C-13 form was computer generated and pre-loaded with medical information gathered on previous occasions. There was no way of knowing when the information was previously gathered or whether it was still in fact relevant to the prisoner.

3. A guard be delegated to monitor a prisoner/prisoners on CCTV if medical or safety issues arise. This guard would be required to watch the prisoner to ensure maximum supervision.

Coroner's Comment: The jury heard evidence that it was not practice to delegate a guard to constantly watch the monitor when a medical issue had arisen or was suspected.

4. The paperwork for heavily intoxicated persons coming to cells overnight to aid in becoming sober be changed from paper filing to computer database filing. This would help determine the frequency of an individual being placed in cells to sober up as well as keep track of medical history.

Coroner's Comment: The jury heard evidence that the current paper system did not allow for the tracking of prisoner's previous visits and did not enable them to track a prisoner's medical history.

5. The three RCMP policies (national, provincial and detachment) concerning prisoner safety be explained to its members to avoid confusion as to why there are three policies and which one to follow at what time.

Coroner's Comment: Self-explanatory

6. BCAS crew reports should be mandatorily attached to the C-13 form going into cells.

Coroner's Comment: The jury heard evidence that the BCAS crew reports were not always obtained by police officers and therefore did not always accompany the prisoner to the cells. In this case, guards were unaware of the medical issues written on Mr. Walker's BCAS crew report which did accompany him to the cells.

BRITISH COLUMBIA

To: Chief Superintendent Fraser McRae
Surrey RCMP detachment
14355 – 57th Avenue
Surrey, BC V3X 1A9

To: Mr. Murray Dinwoodie
City Manager
City of Surrey
14245-56th Avenue
Surrey, BC V3X 3A2

We recommend that:

7. Audio should be included within the CCTV in the Surrey detachment cells.

Coroner's Comment: The jury heard evidence that there was no audio facility in the CCTV system in the cells and therefore what a prisoner or other person said in the cells was not recorded.

8. Modifications be made to two cells in the Surrey RCMP detachment to accommodate prisoners with difficulties with motor skills. Specifically, the beds be lowered significantly to avoid serious injury from a prisoner falling off the beds.

Coroner's Comment: The jury heard evidence that the beds were a few feet off the floor and vulnerable prisoners would sometimes fall off the bed onto the hard concrete floor.

To: Deputy Commissioner Gary D. Bass
Commanding Officer of "E" Division
Royal Canadian Mounted Police
5255 Heather Street
Vancouver BC V5Z 3L7

To: Chief Superintendent Fraser McRae
Surrey RCMP detachment
14355 – 57th Avenue
Surrey, BC V3X 1A9

To: Dr. Nigel Murray, President and CEO
Fraser Health
#300-10334 152A Street
Surrey, BC V3R 7P8

To: Honourable Kevin Falcon, Minister of Health
Ministry of Health
PO Box 9050
Stn Prov Govt
Victoria, BC V8W 9E2

We recommend that:

9. A medical practitioner be assigned to the Surrey RCMP cells to acquire medical records for prisoners, aid in medical issues regarding prisoners as well as to aid in prisoner checks with guards to lessen the chance of emergencies.

Coroner's Comment: The jury heard evidence that there was a regular daily need for BCAS to attend the cells at the Surrey detachment for transportation to hospital (as often as 5-10 times a day on occasions) and that paramedics were not qualified to provide the assessments required. They heard evidence that the Vancouver police detachment, which is smaller in size to the Surrey detachment, has the benefit of a nurse assigned to the cells.

10. A sobriety and detoxification centre be built in Surrey with a specific section for police-apprehended persons intoxicated by alcohol or drugs.

Coroner's Comment: The jury heard evidence that there was no current facility in Surrey. A number of witnesses both from law enforcement and the medical profession told the jury that the police cells were not the right place for people who were intoxicated. The jury also heard there were not adequate detoxification facilities to assist those addicted to alcohol and drugs.

To: Les Fisher
Chief operating Officer
BC Ambulance Service
PO Box 9600, Stn Prov Govt
Victoria, BC V8W 9P1

We recommend that:

11. BCAS crew reports always be given to police officers when involved with assessing or treating a prisoner in order that the police officer can then attach it to the prisoner's C-13 form.

Coroner's Comment: The jury heard evidence that the BCAS crew reports were sometimes not filled out by BCAS paramedics and not given to police officers.

To: Honourable Kevin Falcon, Minister of Health
Ministry of Health
PO Box 9050
Stn Prov Govt
Victoria, BC V8W 9E2

To: Les Fisher
Chief Operating Officer
BC Ambulance Service
PO Box 9600, Stn Prov Govt
Victoria, BC V8W 9P1

We recommend that:

12. A system be devised to enable a patient's medical history to be assessable to BCAS personnel.

Coroner's Comment: The jury heard evidence that there was no process/procedure in place to allow paramedics to know the medical history of an individual they were treating other than by asking the individual, if that was possible.

To: Les Fisher
Chief Operating Officer
BC Ambulance Service
PO Box 9600, Stn Prov Govt
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To: Deputy Commissioner Gary D. Bass
Commanding Officer of "E" Division
Royal Canadian Mounted Police
5255 Heather Street
Vancouver BC V5Z 3L7

To: Honourable Michael de Jong
Solicitor-General of BC
PO Box 9053, Stn Prov Govt
Victoria, BC V8W 9E2

We recommend that:

13. A communication procedure be put in place whereby when the police place a call to the BCAS, they relay the name of the individual requiring assistance to the BCAS dispatcher in

order that the dispatcher is then able to provide the attending paramedics with the individual's medical history.

Coroner's Comment: The jury heard evidence that there was no procedure in place to allow paramedics to know the medical history of an individual in the custody of the police. They also heard that the dispatcher was not provided with the name of the person requiring assistance so even if there were such a process/procedure in place, the name of the individual would need to be provided in advance to ensure paramedics were properly informed prior to attendance.