BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.:2008-0364-1107

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

in the Province of British Columbia, on the following dates August 10-13, 2010

before Vincent M. Stancato, Presiding Coroner,

into the death of Young (Last Name,) Ian Alexander (First Name) 55 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: October 19, 2008 @ 1440 hours

Place of Death: Royal Columbian Hospital (Location) New Westminster, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Massive Brain Injury

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Blunt Force Cranio-Cerebral Trauma

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: Chronic Alcoholism

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

The above verdict certified by the Jury on the 13 day of August AD, 2010.

VINCENT M. STANCATO
Presiding Coroner's Printed Name

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

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

FILE NO.:2008-0364-1107

YOUNG	IAN ALEXANDER
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Vincent M. Stancato

Inquest Counsel: Mr. Rodrick MacKenzie

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Counsel/Participants: Mr. David Kwan, counsel for the RCMP/Attorney General of Canada
Mr. Cameron Ward; Mr. Diego Solimano (articled student), counsel for Karen Young
Mr. David Butcher; Ms. Maegan Richards, counsel for the District of Maple Ridge
Mr. Ian Wiebe; Ms. Pamela Manhas; Ms. Tara Callan, counsel for the BC Ambulance Service

The Sheriff took charge of the jury and recorded 15 exhibits as entered. Twenty two witnesses were duly sworn in and testified. The evidence of two witnesses was provided by video deposition.

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 October 17, 2008 Mr. Ian Young was socializing and drinking beer with friends at the By Bailey Pub in Maple Ridge. He was dropped off at the pub at approximately 1800 hours by his spouse. A bartender and two waitresses at the pub testified that they knew Mr. Young very well as he was a regular patron. The staff recalled serving him Molson Canadian beer, as this was his drink of choice. Based on their testimony, he was served approximately 6-8 beers during his stay. The staff members and friend testified that Mr. Young did not show the effects of being overly intoxicated and seemed like himself, aside from being a little more quiet than usual. At approximately 2100 hours, one of the waitresses that served Mr. Young that evening was off shift. As she was driving home, she saw Mr. Young walking northbound on the west side of Dartford Street. She testified that he was staggering, so she stopped her vehicle and called out the window to Mr. Young, offering him a ride home. She testified that Mr. Young declined her assistance.

On October 17, 2008 at approximately 2125 hours, a citizen was driving on Waresley Street just past 115A Avenue heading toward 115 Avenue when he observed a man, later identified as Mr. Young, lying partially on the sidewalk and partially on the road. The citizen stopped his vehicle to render assistance. He asked Mr. Young if he was okay and Mr. Young responded that he was. The citizen testified that Mr. Young made a remark about his "head smacking the pavement", but he could not recall if this was in response to a question or not. The concerned citizen called 911 and reported the incident.

BC Ambulance Service paramedics arrived at the scene at 2131 hours. They were briefed by the citizen who testified that he informed the paramedics of the statement made by Mr. Young regarding his "head smacking the pavement". The paramedic testified that he could not recall if he was informed of this by the citizen, but believes he was not. The paramedic attended to Mr. Young and assessed him. He noted his pulse, heart rate and blood pressure. He testified that he checked Mr. Young's level of consciousness and attributed a Glasgow Coma Score of 15/15 (highest score) to him, despite the fact that Mr. Young did not know where he was and needed assistance to ambulate. The paramedic testified that he observed an abrasion to the back of Mr. Young's head. Following his assessment, the paramedic formed the opinion that Mr. Young's injuries were not serious and he was intoxicated. Both paramedics testified that they wanted to take Mr. Young to the hospital to get checked out, but he refused. The paramedics were informed that Mr. Young resided a few houses away from where he was found, so one of the paramedics attended the residence. The paramedic that attended the residence testified that he spoke to Mrs. Young and informed her that Mr. Young was found intoxicated on the street. The paramedic testified that he offered to deliver Mr. Young to the residence and Mrs. Young refused to accept him as she was caring for their young daughter and a friend that was sleeping over. Of note, Mrs. Young testified that she was never made aware of Mr. Young's exact condition. She was told that he was intoxicated, but was not informed that he may have struck his head on the pavement.

At approximately 2141 hours, the BC Ambulance Service contacted the Ridge Meadows RCMP to advise they had a highly intoxicated male and requested RCMP to assist. A police officer arrived on scene at 2154 hours. The officer approached the paramedics as they were attending to Mr. Young who was sitting on the back bumper of the ambulance.

The paramedics informed the police officer that they had already assessed him as highly intoxicated. According to the officer, the paramedics stated that they asked Mr. Young about going to the hospital on a few occasions, but he refused. The police officer testified that Mr. Young appeared intoxicated and was slurring his words. The police officer also testified that the paramedics informed her about Mr. Young's address and the earlier conversation between the paramedic and Mrs. Young. The police officer decided to speak with Mrs. Young herself. The police officer's evidence was that she attended the residence and asked Mrs. Young if Mr. Young could be brought home, but she declined to accept him for the same reason she gave to the paramedic earlier. The police officer testified that she informed Mrs. Young that Mr. Young would be lodged in cells for the night and likely released in the morning when sober. The police officer returned to the ambulance and Mr. Young was still sitting on the bumper. The police officer testified that, upon her return, one of the paramedic's showed her the crew report detailing his assessment. At this time the paramedic made reference to an abrasion on the back of Mr. Young's head, but noted that he had checked it out. The officer testified that the paramedic's opinion was that Mr. Young was intoxicated, but otherwise fine. The police officer testified that Mr. Young was "cleared for cells" by the paramedic.

At approximately 2209 hours, the police officer arrested Mr. Young for being "Intoxicated in a Public Place". Mr. Young was transferred to the police vehicle by the paramedics. At this point he was not able to ambulate on his own or "self-assist". The paramedics and police officer testified that they had difficulty placing Mr. Young into the back of the police cruiser and that they were only able to do so with the aid of a stretcher to lift him up to the level of the rear seat. Once he was elevated, one of the paramedics pulled him in to the vehicle from the

opposite rear door. Mr. Young was transported to the Ridge Meadows RCMP Detachment and was booked into cells at 2233 hours. Mr. Young was conscious, but not rousable, upon arrival at the detachment – video evidence depicts him being dragged to a cell with the use of a blanket by a jail guard and RCMP Sergeant.

The jail guards testified that they conducted regular checks of the cell throughout the evening. A review of the prison log shows that the guards recorded that Mr. Young was either "sleeping" or "resting" on each occasion. A review of the cell video shows that Mr. Young did not move at all for the entire period of his incarceration.

At approximately 0250 hours, a jail guard testified that he had become concerned about Mr. Young's condition as he had not moved at all since he came on shift at midnight. He called the Watch Commander to advise him of this fact and was told that Mr. Young was checked out by paramedics and was determined to be intoxicated. A physical check was therefore not conducted.

On October 18, 2008 at approximately 0600 hours, the cell guard checked on Mr. Young and observed that he had vomited and appeared to be unconscious. The Watch Commander attended the cell block and entered the cell with the jail guard and found Mr. Young unresponsive. The BC Ambulance Service was contacted and transported Mr. Young to Ridge Meadows Hospital where he was diagnosed with a severe traumatic head injury. Mr. Young was transferred to Royal Columbian Hospital where he underwent surgery in an attempt to alleviate swelling to his brain. Despite surgery, Mr. Young succumbed to his injury and died on October 19, 2008 at 1440 hours.

BRITISH COLUMBIA

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FILE NO.:2008-0364-1107

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Pursuant to Section 38 of the Coroner's 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: Royal Canadian Mounted Police
Gary Bass, Deputy Commissioner - "E" Division
5255 Heather Street
Vancouver, BC V5Z 1K6

1. That the RCMP consider amending the current "rousability" policy to include a physical check (by entering the cell) of prisoners with questionable consciousness or extreme intoxication every hour to assess their condition. Regular and random monitoring for quality assurance should be conducted by senior members of the RCMP. "Questionable consciousness" means a state of reduced awareness in which a person is not readily responsive.

Coroners Comment: The jury heard testimony concerning, and was provided with, the current RCMP Policy regarding rousability and consciousness. The current policy is adequate and clear; however, testimony suggests that it was not followed in this instance. The jury also heard that the guards currently assess inmates from outside of the cell (or by video) for safety purposes and that the checks are "observational" and not "physical".

2. That the RCMP considers removing the "cleared for cell" concept by BC Ambulance Service from their current practice.

Coroners Comment: The jury heard that it is very common for the police to rely on the paramedic's assessment of presumably intoxicated patients in the field prior to lodging the person into cells. They also heard that an intoxicated person may present with the same symptoms as a person suffering from a head injury or other medical condition (e.g. diabetes) and that the best course of action is to have the person assessed by a physician. Dr. Kim, an emergency room physician, testified that, in any case where a person is presenting as intoxicated and may have a history of falling, the most appropriate course of action is to bring the person to the hospital. Dr. Kim testified that hospital staff has the appropriate expertise and equipment to properly assess the patient's condition.

3. That all senior RCMP members (with "Watch Commander" duties) receive Level II first aid training.

Coroners Comment: Self explanatory.

4. That the RCMP amends its current policy to ensure that the cell guard duty logbook contains all pertinent information in regards to a prisoners ongoing condition.

Coroners Comment: The jury was provided with copies of the prison logbook and relevant policy. The prison log contains very limited information about the prisoner's condition. In most instances the guards simply record the time of a check and provide a short statement like "prisoner sleeping" or "prisoner resting". A review of the log revealed that the jail guards make very few comments about prisoner movements and/or prisoner response to verbal prompts.

5. Consider a review of cell (drunk tank) conditions - flooring, access to blankets and safe transfer procedures to and from the cell.

Coroners Comment: The jury heard testimony from the jail guard and police regarding the conditions of the cell and the method used to transport Mr. Young from the police cruiser to the cell. They also viewed video footage of his transfer which showed that he could not ambulate on his own and that he was placed onto a blanket and dragged to his cell. During this time he was still considered to be "roused"/"responsive" by police staff. The jury also heard testimony and viewed video which showed that Mr. Young was placed onto the cell floor without a blanket, despite the fact that one was used to drag him into the cell. The jury also heard and viewed evidence that Mr. Young's cell mate was provided with a blanket.

6. That the entire verdict with recommendations and Coroner's Comments be circulated to all RCMP Non-Commissioned Officers and jail guards in British Columbia.

Coroners Comment: The jury heard testimony from both police and jail guard staff that, from time to time, they have been made aware of Coroner's Jury recommendations, but that they do not get copies of the actual Verdict. The communication regarding policy changes is usually made via an internal memorandum. The reason behind the change and any supporting documentation is rarely shared.

To: BC Ambulance Service
Mr. Les Fisher, A/Chief Operating Officer
PO BOX 9600, STN PROV GOVT.
Victoria, BC V8W 9P1

7. That the BCAS consider amending the current patient care report to include an area for special instructions directed to police when transfer of care occurs in an individual who displays symptoms of intoxication or head injury. The report should also include a "transfer of subject" that would document the transfer and release of care. An alternative would be to develop a supplemental form that can be attached to the Patient Care Report which outlines these instructions. (May consider using a similar sheet to what physicians/nurses are currently providing to hospital patients).

Coroners Comment: The jury heard evidence from both paramedics and the police that the current "crew report" does not provide a section for special instructions regarding patient care to police or other caregivers (i.e. family members) upon release or transfer of care. The police officer testified that nothing was provided to her, either verbally or in writing, regarding appropriate patient care. The jury heard from an emergency room physician that information sharing among caregivers is critical, especially with an individual who displays symptoms of intoxication or a head injury. The emergency room physician testified that hospitals provide caregivers with a sheet detailing what conditions to watch for prior to releasing anyone who may have suffered a head injury. This information sheet also provides instructions about what to do if the patient's condition worsens.

8. That the BCAS consider implementing a policy that anyone displaying signs of intoxication where there is a reported history or physical evidence of head trauma is taken directly to hospital for assessment. In such circumstances where there is a competition between intoxication and/or possible head injury the paramedic must default to head injury, similar to hospital staff.

Coroners Comment: Self explanatory.

9. The BCAS consider amending the patient care report to include a "reason for dispatch" area, to be completed at the time of dispatch, which would contain incident particulars preparing the attendant for scene arrival (may be coded and assigned by BCAS staff).

Coroners Comment: The jury heard testimony from a civilian witness that he communicated to the 911 dispatcher that Mr. Young may have smacked his head on the pavement. The jury listened to a recording of the 911 call which confirmed the civilian's testimony. The jury heard testimony from the paramedic that he was not provided with information regarding a possible head injury by the dispatcher prior to arriving at the scene, nor was this communicated to him at the scene by the civilian. The paramedic testified that he did find an abrasion on the head but that he was unaware of Mr. Young's comment to the civilian that he may have smacked his head. A review of the crew report also revealed no area for the paramedic to document the reason for dispatch. This area would allow for the paramedic to write down key information to prepare him/her in advance of the patient's assessment. It would also assist in verifying communication between paramedic and dispatcher.

10. The BCAS consider Mobile Work Station Terminals for all ambulances.

Coroners Comment: This recommendation is linked to recommendation 9 with a purpose to further improve communication between the paramedic and dispatcher. The jury heard that police cruisers are so equipped.

11. The BCAS consider a review of current paramedic training requirements, qualifications and quality of care. It is also recommended that quality assurance checks are performed by supervisors.

Coroners Comment: The jury heard that the paramedics that attended to Mr. Young received their initial training many years ago. They also heard that, aside from the initial training (EMA 1 & 2), paramedics are required to complete 20 credits (internal training) annually. The jury heard from one of the paramedics who testified that he has not received any updated training on head injuries and he is not aware of any specific policy regarding the assessment of head injuries.

12. That the BCAS consider assigning an AMPDS (Advanced Medical Priority Dispatch System) code that is passed on to the ambulance dispatcher.

Coroners Comment: Self explanatory

To: Royal Canadian Mounted Police
Gary Bass, Deputy Commissioner - "E" Division
5255 Heather Street
Vancouver, BC V5Z 1K6

To: BC Ambulance Service
Mr. Les Fisher, A/Chief Operating Officer
PO BOX 9600, STN PROV GOVT.
Victoria, BC V8W 9P1

13. That the BCAS/RCMP consider the following: In cases where paramedics and/or police believe that intoxication or other illness has impaired the person's ability to make a rational decision regarding the need for medical treatment that the common law permits the person to be transported for medical treatment.

Coroners Comment: The jury heard that Mr. Young was asked by the paramedic to go to the hospital on at least three occasions, but refused each time. They also heard and viewed video evidence that suggests Mr. Young was not capable of making a rational decision with respect to his own well being and personal need for medical treatment.

To: Dr. Nigel Murray, President and CEO
Fraser Health Authority, Province of BC
300 - 10334 152A Street
Surrey, B.C. V3R 7P8

14. That the Fraser Health Authority consider developing sobering centres (and/or mobile detoxification unit with qualified staff), such that emergency responders have an alternative to hospital or jail.

Coroners Comment: The jury heard that first responders and police are usually faced with only two options when they encounter a person that presents as intoxicated in a public place – hospital or jail. If the person refuses medical treatment at hospital they are almost always transported to jail because of the lack of any other community resource/option.

To: Mr. Rich Coleman
Minister of Housing and Social Development
PO Box 9058, Stn Prov Govt
Victoria BC V8W 9E1

15. The Liquor Control Branch consider a review of the "Serving it Right" Program with a view of amending policy, requirements, testing and re-qualification.

Coroners Comment: The jury heard from the toxicologist and pathologist that Mr. Young had toxic levels of alcohol in his system when found on the street (estimated to be approximately 0.45% - roughly the equivalent of 22 beers). They also heard evidence from staff that Mr. Young was served between 6 and 8 beers while at the pub. There was no evidence to establish clearly where or when Mr. Young consumed the alcohol to achieve such high ethanol levels. Additionally, staff members at the By Bailey Pub testified that they each took the Serving it Right Program at some point early on in their serving careers, but that the program does not have a test associated with it, nor is there any re-certification or re-training requirement.