Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

33File No.: 2009:0448:0066

An Inquest was held at the Supreme Court, in the municipality of Cranbrook

in the Province of British Columbia, on the following dates July 4 - 6, 2011

before Mr. T.E. Chico Newell, Presiding Coroner,

into the death of ASMUNT, Marvin Eugene (Last Name, First Name Middle Name) 61 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: **SEPTEMBER 18, 2009 1930 HRS**

Place of Death: Creston Valley Hospital (Location) Creston BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death:	a) Bilateral Pneumonia and Pericarditis
	DUE TO OR AS A CONSEQUENCE OF
Antecedent Cause if any:	b) Aspiration due to Decreased Level of Consciousness
	DUE TO OR AS A CONSEQUENCE OF
Giving rise to the immediate cause (a) above, stating underlying cause last.	c) Closed Head Injury Due to Recent Trauma
(2) Other Significant Conditions Contributing to Death:	Alcohol

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

The above verdict certified by the Jury on the 6 day of July AD, 2011.

T.E. Chico Newell
Presiding Coroner's Printed Name

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT INQUEST

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

FILE NO.: 2009:0448:0066

ASMUNT	Marvin Eugene
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	T.E. Chico Newell
Inquest Counsel:	Mr. Rodrick Mackenzie
Court Recording Agency:	Verbatim Recording Services
Counsel for Participants:	Mr. David Kwan for Attorney General of Canada
	Mr. David Pilley for Drs. S. Walker, C. Armstrong, & A. Weaver.

The Deputy Sheriff took charge of the Jury and recorded 2 exhibits.
Fifteen witnesses were duly sworn 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 is not intended to be considered evidence nor is it intended in any way to replace the Jury's verdict.

The Jury heard testimony that during the late afternoon of September 7, 2009, Marvin Eugene Asmunt was arrested in Creston by a RCMP constable under the LIQUOR CONTROL AND LICENSING ACT for being drunk in a public place. Mr. Asmunt was transported via police vehicle to the local RCMP Detachment. The police officer's account included that Mr. Asmunt reportedly resisted verbal efforts by the officer at placing him into a jail cell by holding onto the right side of the cell door frame with his right hand while standing still. The officer had control of Mr. Asmunt's left arm. The officer used the palm of his hand on Mr. Asmunt's shoulder to no avail. The officer subsequently lowered his shoulder into Mr. Asmunt's back. Mr. Asmunt then reportedly fell over striking his head on the floor of the jail cell. The officer assessed Mr. Asmunt and found him to be unconscious and bleeding from the head onto the floor. The officer placed him into the 'recovery position' and then called the dispatcher for an ambulance. There were no direct independent witnesses. There was no video surveillance.

The Jury heard that paramedics arrived to find Mr. Asmunt unconscious on the jail cell floor with a bleeding scalp laceration and an odour of alcohol. The attending paramedic had completed the basic three week training requirement and had two days field experience. His recollections were relatively few and the Patient Care Report was not fully completed. The second and much more experienced paramedic gave testimony in detail describing the position in which they encountered Mr. Asmunt, the approximately 2 centimetre size of the scalp laceration, the estimated 40-50 millilitres of blood loss, the total period of unconsciousness being about 25 minutes and the course of events leading to the delivery to hospital staff.

The physician who attended Mr. Asmunt in the emergency ward stated that the patient was conscious and responsive to following directions when prompted but was not talking. There was "a powerful smell of alcohol" on his breath. The toxicology report indicated that the blood-alcohol level was 60.7 mmol/L (0.27%). A series of x-rays, excluding Mr. Asmunt's head, revealed no acutely significant findings. Treatment was to observe Mr. Asmunt and do complete routine assessments. The morning following his admission Mr. Asmunt was assessed by the physician who found that he had slurred speech and his gait was unsteady. Both of these symptoms had been noted by the physician about this patient on previous visits. Mr. Asmunt's vital signs were unremarkable. The medical records did not record that he had suffered a seizure nor had he vomited during the night; both of which

are considered signs of significant head injury. Prior to Mr. Asmunt's release from hospital he was offered alcohol substance abuse treatment options which he graciously declined.

The Jury further heard that in the mid-morning of September 9, 2009, one day following his release from hospital, some neighbours of Mr. Asmunt noted he was having difficulty maintaining his balance and found him shivering in an uncontrollable manner. An ambulance was called and a different crew from that which attended the RCMP cell block two days earlier attended. Mr. Asmunt was found to be difficult to understand, shaking, complaining of a sore right hip, drooling, and with no complaint of a headache. That he may have had some seizure activity was considered by a paramedic. He was subsequently transferred to hospital. The attending physician had met Mr. Asmunt previously in the Emergency Department and knew him to be a chronic alcoholic. The physician was not made aware of the September 7, 2009 hospital visit and did not request the prior medical records. The possible post seizure scenario was reportedly not conveyed to the attending physician. Mr. Asmunt was assessed and there was no clear diagnosis. Within an hour of admission he discharged himself from the hospital.

In the late morning of September 13, 2009, Mr. Asmunt was again admitted to the hospital via ambulance, when his friends reported that he had been having seizures. Mr. Asmunt was transferred to the regional hospital in Cranbrook for the purpose of a CT scan which revealed multiple bilateral areas of intracerebral hemorrhage. Mr. Asmunt returned to the hospital in Creston early in the morning of September 14, 2009. Specific medical consultations determined that he was not a candidate for surgical treatment. Mr. Asmunt's condition deteriorated and he became unresponsive by September 17, 2009 and died on September 18, 2009.

The forensic pathologist who performed the autopsy testified that the cause of death was bilateral pneumonia and pericarditis secondary to aspiration. This was due to decreased level of consciousness secondary to a closed head injury due to recent trauma to the left side of the head. The Jury heard that the fall in the jail cell was the underlying cause for Mr. Asmunt's death. The forensic pathologist opined that earlier intervention may have involved surgical treatment which would have brought a different outcome.

ASMUNT	Marvin Eugene
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 RCMP E Division

1) It is recommended that video surveillance be installed in cells, cell block and booking area to ensure and promote prisoner and officer safety.

Coroner's Comment:

There was no video surveillance in the RCMP cell block at that time or to date. The Jury heard that the RCMP has pre-existing plans to install video surveillance in the cell block by the fall of 2012.

2) It is recommended that at least two officers be on duty at all times to lend mutual aid and assistance.

Coroner's Comment:

The Jury also heard that the arresting officer was the sole on-duty RCMP officer in Creston at the time of the fall incident. There was no guard on duty in the cell block at the time of Mr. Asmunt's admission. Another officer was scheduled to be on-call to assist the duty officer and was subsequently called in.

To BC Ambulance Service

3) It is recommended a mentoring program be developed for new recruits to promote the continuity in the giving and receiving of patient information between Ambulance Attendants and Hospital Staff.

Coroner's Comments:

The Jury heard that the paramedics had a range of experience from being basically new to the job to having years of significant experience. Paramedics told the Jury of their belief that the BC Ambulance Service Patient Care Reports or the information contained therein do not routinely get reviewed by the Emergency Department physicians.

To Interior Health Authority

4) We recommend a printed record of previous patient visits be attached to triage chart upon admittance to ER Department to promote continuity of care.

Coroner's Comments:

The Jury heard that the Emergency Department physician who saw Mr. Asmunt on his second visit told of likely not having seen a BC Ambulance Service Patient Care Report when receiving Mr. Asmunt. The physician advised that she was not aware of the visit to hospital two days earlier and did not request/review the existing medical chart. The physician explained retrospectively that having the benefit of the recent patient history would have led her through a different thought process.